IA Health Link

Medicaid Provider Manual

Effective January 1, 2016

Amendment History

Document Version	Changed By	Date	Modifications
1.0		10.11.2015	Amerigroup
1.1	Contract and RFP Review	10.12.2015	Readiness Review Team
1.20	Provider Services	10.13.2015	Policy Review
1.21	LTC Bureau	10.14.2015	Policy Review
1.22	HCBS	10.14.2015	Policy Review
1.22	Medical Services Policy	10.14.2015	Policy Review
1.23	Eligibility	10.14.2015	Policy Review
1.4	IME Leadership Review	10.14.2015	Clarified Comments
1.5	IME Medicaid Modernization Project Management Office	10.15.2015	Returned to MCO for corrections
2.0	Accept corrections and respond to comments	10.19.2015	Amerigroup
2.1	Readiness Review Team IME SME Team	10.21.2014	Cycle 2 – Joint Review
2.2	IME Managed Care Director	10.21.2014	Liz Matney
2.3	IME Medicaid Modernization Project Management Office	10.21.2014	Janelle McDonald
3.0	Accept corrections and respond to comments	10.26.2015	Amerigroup

The master copy of this document is available on line. Hard copies are for information purposes only and are not subject to document control.

Table of Contents

CHAPTER 1: INTRODUCTION 11
Welcome 11
About This Manual 11
Legal Requirements 12
Contacts 12
Before Rendering Services 12
After Rendering Services 12
Operational Standards, Requirements and Guidelines 12
Additional Resources 12
Accessing Information, Forms and Tools on Our Website 13
Websites 13

CHAPTER 2: LEGAL AND ADMINISTRATIVE REQUIREMENTS 14
Proprietary Information 14
Updates and Changes 14

CHAPTER 3: CONTACTS 15
Overview 15
Amerigroup Contacts 15

CHAPTER 4: COVERED AND NONCOVERED SERVICES 20
Covered Services 20
Covered Services: Medicaid Services 20
Covered Services: Iowa Wellness Plan Benefits 29
Covered Services: Family Planning Covered Services 33
Covered Services: Iowa Department of Public Health Covered Services 35
Home and Community Based Services (HCBS) 36
Covered Services: Value-Added Services 36
Covered Services: Healthy Rewards Program 37
State-Covered Services 40
NonCovered Services 40
Services Requiring Precertification 41
Vision Services 42
Nonemergency Transportation Services 42

CHAPTER 5: LONG TERM SERVICES AND SUPPORTS 43
Overview 43
Waiver Descriptions 43
Precertification Requirements 46
Person-centered Case Management Model 46
Initial Discovery, Assessments and Informed Consent 47
Person-Centered Service Planning 48
Incorporating Member Choice in Funding Decisions 48
Identification 48
Processing Referrals to LTSS Services 49
Transition and Discharge Planning 50
Discharge Planning 50

Responsibilities of the LTSS Provider 51
Consumer Direction (Consumer Choice Option) 51
Electronic Visit Verification 51
Facility Member Liability 52
Nursing Facility Preadmission Screening and Resident Review 53
LTSS Continuity of Care 54

CHAPTER 6: BEHAVIORAL HEALTH SERVICES 56
Overview of Behavioral Health at Amerigroup 56
Goals 56
Values 56
Principles 56
Objectives 57
Recovery and Resiliency 57
General Provider Information 60
Health Home Services 60
Services Requiring Precertification 62
Member Records and Treatment Planning 62
Adverse Incident Reporting (including Psychiatric Medical Institution for Children, Children's Mental Health Waiver and Habilitation Program Services) 64
Psychotropic Medication 64
Utilization Management Process 65
Behavioral Health Authorization Time Standards 66
Notification or Request Preauthorization 66
Clinical Criteria 66
Behavioral Heath Medical Necessity Determination and Peer Review 67
Nonmedical Necessity Adverse Decisions 67
Provider Appeals, Grievance and Payment Disputes 68
Avoiding and Adverse Decision 68
Behavioral Health Drug Utilization Review Program 70
Post-Discharge Outreach, Diversion Plans and Crisis Assessments 70
Clinical Practice Guidelines 71
Provider Training 72
Behavioral Health Waivers 72

CHAPTER 7: MEMBER ELIGIBILITY 73
Overview 73
How to Verify Member Eligibility 73
IA Health Link ID Cards 73

CHAPTER 8: MEDICAL MANAGEMENT 75
Overview 75
Services Requiring Precertification 76
Services Not Requiring Precertification 77
Starting the Process 77
Requesting Precertification 78
Chronic Condition Health Home and Integrated Health Home 79
Requests with Insufficient Clinical Information 80

Urgent Requests 80
Emergency Medical Services 81
Emergency Stabilization and Post-Stabilization 81
Concurrent Review: Hospital Admissions 81
Concurrent Review: Clinical Information for Continued-Stay Review 81
Concurrent Review: Second Opinions 82
Denial of Service 82
Referrals to Specialists 83
Additional Services: Behavioral Health 83
Additional Services: Vision Care 84

CHAPTER 9: HEALTH SERVICES PROGRAMS 85
Overview 85
Preventive Care: Initial Health Assessments 85
Preventive Care: Well Woman 86
Preventive Care: Taking Care of Baby and Me® 86
Preventive Care: Long-acting Reversible Contraception 87
Health Management: Disease Management Centralized Care Unit 88
Health Management: Healthy Families 89
Health Management: Women, Infants and Children 89
Health Education: Amerigroup On Call 90
Health Education: Drug Lock-In Initiative 90
Health Education: Smoking Cessation 90
Provider Assessment of Smoking Use 91

CHAPTER 10: CLAIMS AND BILLING 92
Overview 92
Submitting “Clean” Claims 92
Methods for Submission 93
Web Portal Submission 93
Electronic Claims 93
Paper Claims 94
National Provider Identifier 95
Atypical Providers 96
Enrollment in Iowa Medicaid 96
International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10 CM) 96
Claim Filing Limits 96
Claim Forms and Filing Limits 97
Other Filing Limits 97
Claims from Non-contracted Providers 98
Member Copayments and Balance Billing 98
Member Liability / Client Participation 99
Coordination of Benefits 99
Subrogation 100
Claims Filed With the Wrong Plan 100
Payment of Claims 101
Monitoring Submitted Claims 101

Electronic Fund Transfer 101
Electronic Remittance Advice 101
Claims Overpayment Recovery Procedure 101
Third-Party Recovery 102
Claim Resubmissions 103
Claims Returned for Additional Information 103
Claims Payment Appeals 103
Timeline for Claims Payment Appeals 104
Reference: Covered Services 104
Reference: Clinical Submissions Categories 104
Reference: Common Reasons for Rejected and Returned Claims 106
Reimbursement Policies 107
Acute Care Hospitals / Critical Access Hospitals 109
Ambulatory Service Center 111
Behavioral Health Facility 111
Federally Qualified Health Center (FQHC) and Rural Health Clinics (RHC) 112
Intermediate Care Facility 112
Skilled Nursing Facility 112

CHAPTER 11: BILLING PROFESSIONAL AND ANCILLARY CLAIMS 113
Overview 113
Coding 114
Initial Health Assessments 114
Adult Preventive Care 114
Preventive Medicine Services: New Patient 115
Preventive Medicine Services: Established Patient 115
Behavioral Health 116
Emergency and Related Professional Services 116
Family Planning Services 117
Immunizations Covered By Vaccines for Children 119
Immunizations Coding 122
Maternity Services 122
Maternity Services: Newborns 122
Newborns: Circumcision 124
Sensitive Services 124
Sterilization 126
Hysterectomy 127
Termination of Pregnancy 128
Billing Members for Services Not Medically Necessary 129
Recommended Fields for CMS-1500 129

CHAPTER 12: BILLING INSTITUTIONAL CLAIMS 130
Overview 130
Basic Billing Guidelines 130
Emergency Room Visits 131
Urgent Care Visits 132
Maternity Services 132

Termination of Pregnancy 133
Inpatient Acute Care 133
Inpatient Sub-Acute Care 134
Outpatient Laboratory, Radiology and Diagnostic Services 134
Outpatient Surgical Services 135
Outpatient Infusion Therapies and Pharmaceuticals 135
Ancillary Billing Overview 136
Ambulance Services 136
Ambulatory Surgical Centers 136
Physical, Speech and Occupational Therapies 137
Durable Medical Equipment 137
Durable Medical Equipment: Rentals 137
Durable Medical Equipment: Purchase 137
Durable Medical Equipment: Wheelchairs and Wheeled Mobility Aids 138
Dialysis 138
Home Infusion Therapy 138
Laboratory and Diagnostic Imaging 138
Skilled Nursing Facilities 139
Home Health Care 139
Hospice 139
Additional Billing Resources 139
CMS-1450 Claim Form 139
CMS-1450 Revenue Codes 141
Institutional Inpatient Coding 141
Institutional Outpatient Coding 141
Recommended Fields for CMS-1450 141

CHAPTER 13: MEMBER TRANSFERS AND DISENROLLMENT 142
Overview 142
PCP-Initiated Member Transfers 142
PCP-Initiated Member Disenrollment 143
State Agency-Initiated Member Disenrollment 143
Member-Initiated PCP Reassignment 143
Member-Initiated Disenrollment Process 144
Member Transfers to Other Plans 144
Amerigroup -Initiated Member Disenrollment 145

CHAPTER 14: GRIEVANCES AND APPEALS 146
Overview 146
Providers: Grievances Relating to the Operation of the Plan 147
Providers: When to Expect Resolution for a Grievance or Appeal 147
Providers: Appeals Related to Adverse Determinations 148
Providers: Appeals Related to Non-Medical Necessity Claims Determinations 148
Providers: Mediation and Arbitration 149
Members: Filing a Grievance 149
Members: Resolution 150
Members: Appeals 150

Members: Response to Standard Appeals 150
Members: Resolution of Standard Appeals 151
Members: Extensions 151
Members: Expedited 151
Members: Timeline for Expedited Appeals 151
Members: Response to Expedited Appeals 151
Members: Resolution of Expedited Appeals 152
Members: Other Options for Filing Grievances 152
Members: State Fair Hearing 152
Confidentiality 153
Discrimination 153
Continuation of Benefits during Appeal 153
Additional Options for Filing a Grievance 154

CHAPTER 15: CREDENTIALING AND RE-CREDENTIALING 155
Overview 155
Council for Affordable Quality Healthcare 155
Approved Provider Types 156
Approved Health Delivery Organizations 156
CAQH/UPD Registration: First Time Users 156
CAQH/UPD Registration: Completing the Application Process 157
CAQH/UPD Registration: Existing Users 158
Additional CAQH Resources 158
Contracting Process for Hospital or Facility-Based Providers 158
Credentialing Updates 159
Recredentialing 161
Ownership Disclosure 161
Professional Liability Coverage 161

CHAPTER 16: ACCESS STANDARDS AND ACCESS TO CARE 162
Overview 162
General Appointment Scheduling 162
Services for Members under the Age of 21 163
Services for Members 21 Years and Older 164
Prenatal and Postpartum Visits 164
Wait Times 164
Nondiscrimination Statement 164
Interpreter Services 164
Missed Appointment Tracking 165
After-Hours Services 165
Amerigroup On Call 166
Continuity of Care 166
Provider Contract Termination 168
Newly Enrolled 168
Members Moving Out of Service Area 169
Second Opinions 169
Emergency Transportation 169

Emergency Dental Services for Adults and Children 169
Border City Providers 170

CHAPTER 17: PROVIDER ROLES AND RESPONSIBILITIES 171
Overview 171
Primary Care Physicians 171
Referrals 172
Out-Of-Network Referrals 172
Interpreter Services 173
Transitioning Members between Medical Facilities and Home 173
Noncovered Services 174
Specialists 174
Hospital Scope of Responsibilities 174
Ancillary Scope of Responsibilities 175
Responsibilities Applicable to All Providers 175
Office Hours 176
After-Hours Services 176
Licenses and Certifications 177
Eligibility Verification 177
Collaboration 177
Continuity of Care 177
Medical Records Standards 178
Mandatory Reporting of Child Abuse, Elder Abuse or Domestic Violence 178
Updating Provider Information 178
Oversight of Non-Physician Practitioners 179
Open Clinical Dialogue/Affirmative Statement 179
Provider Contract Termination 179
Termination of the Ancillary Provider/Patient Relationship 180
Disenrollees 180
Provider Rights 180
Prohibited Activities 180
Misrouted Protected Health Information 181

CHAPTER 18: CLINICAL PRACTICE AND PREVENTIVE HEALTH CARE GUIDELINES 182
Overview 182
Clinical Practice Guidelines 182
Preventive Health Care Guidelines 183

CHAPTER 19: CASE MANAGEMENT 184
Overview 184
Provider Responsibilities 185
Referral Process 185
Role of the Case Manager 185
Case Management Procedure 186
Transitioning Disenrollees 186
Continued Access to Care 186
Continuity of Care Process 187
Health Home Services 187

CHAPTER 20: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT 190
Overview 190
Quality Assessment and Performance Improvement Program 191
Healthcare Effectiveness Data and Information Set 191
Quality Management 192
Best Practice Methods 192
Member Satisfaction Surveys 192
Provider Satisfaction Surveys 193
Medical Record and Facility Site Reviews 193
Medical Record Documentation Standards 193
Medical Record Security 193
Storage and Maintenance 194
Availability of Medical Records 194
Medical Record Requirements 194
Advance Directives 195
Medical Record Review Process 196
Facility Site Review Process 196
Facility Site Review: Corrective Actions 197
Preventable Adverse Events 197

CHAPTER 21: ENROLLMENT AND MARKETING RULES 198
Overview 198
Marketing Policies 198
Enrollment Process 199

CHAPTER 22: FRAUD, ABUSE AND WASTE 200
Overview 200
Understanding Fraud, Abuse and Waste 200
Examples of Provider Fraud, Abuse and Waste 200
Examples of Member Fraud, Abuse and Waste 200
Reporting Provider or Recipient Fraud, Abuse or Waste 201
Anonymous Reporting of Suspected Fraud, Abuse and Waste 202
Investigation Process 202
Acting on Investigative Findings 203
False Claims Act 203
Employee Education about the False Claims Act 203

CHAPTER 23: MEMBER RIGHTS AND RESPONSIBILITIES 204
Overview 204
Member Rights 204
Member Responsibilities 205
NCQA Requirements 205

CHAPTER 24: CULTURAL DIVERSITY AND LINGUISTIC SERVICES 206
Overview 206
Interpreter Services 207

CHAPTER 1: INTRODUCTION

Welcome

Welcome to the Amerigroup Iowa, Inc. (Amerigroup) network provider family! We are pleased you have joined our Iowa network, which consists of some of the finest health care providers in the state. Amerigroup has been selected by the Iowa Department of Human Services to provide health care services for Amerigroup Members enrolled in Iowa's Health Link Program.

IAHealth Link Program covers all Medicaid mandatory eligibility groups, as well as various optional categorically needy and medically needy groups, including children, pregnant women, the aged and individuals with disabilities. Amerigroup represents a growing network of health care Providers who make it easier for our Members to receive quality care. There is strength in numbers: Amerigroup's health services programs, combined with those already available in our target service areas, are designed to supplement Providers' treatment plans. Our programs serve to help improve our Members' overall health by informing, educating and encouraging self-care in the prevention, early detection and treatment of existing conditions and chronic disease.

We believe hospitals, physicians and other providers play a pivotal role in managed care. We can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network. Together, we can arrange for and provide an integrated system of coordinated, efficient and quality care for our members and your patients.

All network providers are contracted with Amerigroup through a Participating Provider Agreement.

About This Manual

This Provider Manual is designed for contracted Amerigroup Providers, Hospitals and Ancillary Providers. Our goal is to create a useful reference guide for you and your office staff.

We want to help you navigate our managed health care plan to deliver quality health care to our members. Our goal is to aid you in finding the most reliable, responsible, timely and cost-effective way to deliver quality health care.

We recognize that managing our Members' health can be a complex undertaking, requiring familiarity with the rules and regulations of a complex health care system. This system encompasses a wide array of services and responsibilities; for example, Initial Health Assessments (IHAs), case management, proper storage of medical records, and billing for emergencies. With this complexity in mind, we divided this manual into sections that reflect your questions, concerns and responsibilities before and after an Amerigroup Member walks through your doors. The sections are organized as follows:

- **Legal Requirements**
- **Contact Information**
- **Before Rendering Services**
- **After Rendering Services**
- **Operational Standards, Requirements and Guidelines**
- **Additional Resources**

Legal Requirements

The information contained in this manual is proprietary, will be updated regularly and is subject to change. This section provides specific information on the legal obligations of being part of the Amerigroup network.

Contacts

This section is your reference for important phone and fax numbers, websites and mailing addresses.

Before Rendering Services

This section provides the information and tools you will need before providing services, including verifying member eligibility and a list of covered and noncovered services. The section also includes a chapter on the precertification process and coordination of complex care through our Case Management department.

We take pride in our proactive approach to health. The chapter on Health Services programs details how we can partner with you to make the services you provide more effective. For example, the Initial Health Assessment is our first step in providing preventive care. The health services programs under Disease Management Centralized Care Unit (DMCCU) allow us to collaborate with you to combat the most common and serious conditions and illnesses facing our members, including asthma, cardiovascular disease and diabetes.

After Rendering Services

At Amerigroup, our goal is to make the billing process as streamlined as possible. This section provides guidelines, detailed coding charts, information on filing claims for professional and institutional services rendered The Member Transfer and Disenrollment chapter outlines how a member changes primary care physician (PCP) assignment or tranfers to another health plan. When questions or concerns come up about claims or adverse determination, our chapter on Grievances and Appeals will take you step-by-step through the process.

Operational Standards, Requirements and Guidelines

This section summarizes the requirements for provider office operations and Access Standards, thereby ensuring consistency when members need to consult with providers for IHAs, referrals, coordination of care and follow up care. Additional chapters detail Provider Credentialing, Provider Roles and Responsibilities and Enrollment and Marketing guidelines. Chapters on Clinical Practice and Preventive Health Guidelines and Case Management outline the steps providers should take to coordinate care and help members take a pro-active stance in the fight against disease. And finally, we included a chapter documenting our commitment to participate in Quality Assessments that help Amerigroup measure, compare and improve our standards of care.

Additional Resources

To help providers serve a diverse and ever-evolving patient population, we designed a special program, Cultural Diversity and Linguistic Services, to improve provider and member communications by providing tools and resources to help reduce language and cultural barriers. In addition, Amerigroup works with nationally-recognized health care organizations to stay current on the latest health care breakthroughs and

discoveries. This manual provides easy links to access that information. We also provide forms and reference guides on a wide variety of subjects.

Accessing Information, Forms and Tools on Our Website

We offer the Provider Manual in hard copy upon request at no cost and post it online.

A wide array of tools, information and forms are accessible via the **Providers** page of our website: **providers.amerigroup.com/ia.** Throughout this manual, we often will refer you to items located on this resource page. To access this page, please follow these steps:

Using the **Provider Manual**: Click on any topic in the **Table of Contents** to view that chapter. Click on any web address to be redirected to that site. Each chapter also may contain cross-links to other chapters, to the Amerigroup website or to external websites containing additional information.

If you have any questions about the content of this manual, contact Provider Services at <<1-800-454-3730>>. Hours: Monday through Friday, 7:30 a.m.-6 p.m. Central time

Websites

The Amerigroup website and this manual may contain links and references to Internet sites owned and maintained by third-party sites. Neither Amerigroup nor its related affiliated companies operate or control, in any respect, any information, products or services on third-party sites. Such information, products, services and related materials are provided “as is” without warranties of any kind, either express or implied, to the fullest extent permitted under applicable laws. Amerigroup disclaims all warranties, express or implied, including, but not limited to, implied warranties of merchantability and fitness. Amerigroup does not warrant or make any representations regarding the use or results of the use of third-party materials in terms of correctness, accuracy, timeliness, reliability or otherwise.

CHAPTER 2: LEGAL AND ADMINISTRATIVE REQUIREMENTS

Legal and Administrative Requirements
Proprietary Information

The information contained in this manual is proprietary. By accepting this manual, providers agree:

- To use this manual solely for the purposes of referencing information regarding the provision of medical services Iowa Medicaid enrollees who have chosen Amerigroup as their health care plan
- To protect and hold the manual's information as confidential
- Not to disclose the information contained in this manual

Legal and Administrative Requirements
Updates and Changes

The Provider Manual, as part of your Provider Agreement and related Addendums, may be updated at any time and is subject to change. In the event of an inconsistency between information contained in the manual and the Provider Agreement between you or your facility and Amerigroup, the Provider Agreement shall govern.

In the event of a material change to the Provider Manual, we will make all reasonable efforts to notify you in advance of such change through web-posted newsletters, email notifications, fax communications (such as provider bulletins), and/or other mailings. In such cases, the most recently published information should supersede all previous information and be considered the current directive.

The manual is not intended to be a complete statement of all Amerigroup policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially targeted communications, as referenced above.

This manual does not contain legal, tax or medical advice. Please consult your own advisors for such advice.

CHAPTER 3: CONTACTS

Contacts
Overview

When you need the correct phone number, fax number, website or street address, the information should be right at your fingertips. With that in mind, we have compiled the most-used contacts for you and your office staff for Amerigroup services and support.

Contacts
Amerigroup Contacts

If you have questions about. . .	Contact
Behavioral Health Services	**Amerigroup Medical Management** Phone: <<1-800-454-3730>> TTY: <<711>> Hours: Monday to Friday, 7:30 a.m.-6 p.m. Central time. Fax: <<INSERT PHONE #>> (Inpatient) <<INSERT PHONE #>> (Outpatient)
Case Management Referrals	**Amerigroup Medical Management** Phone: <<1-800-454-3730>> TTY: <<711>> Hours: Monday to Friday, 7:30 a.m.-6 p.m. Central time. Fax: <<INSERT PHONE #>>
Claims: Electronic Processing	**Amerigroup Provider Services** **EDI Solutions Help Desk**: <<1-800-590-5745>> Hours: Monday to Friday, 7:30 a.m.-6 p.m. Central time Providers have three options to submit electronic claims: • Availity: payer ID 26375 for professional and institutional claims • Emdeon: payer ID 27514 for professional and institutional claims • Capario: payer ID 28804 for professional and institutional claims
Claims: Payment Status	**Amerigroup Provider Services** Phone: <<1-800-454-3730>> TTY: <<711>> Hours: Monday to Friday, 7:30 a.m.-6 p.m. Central time Fax: <<INSERT PHONE #>>

If you have questions about. . .	Contact
Claims: Appeals/Correspondence	**Amerigroup Provider Services** Phone: <<1-800-454-3730>> Hours: Monday to Friday, 7:30 a.m.-6 p.m. Central time Fax: <<INSERT PHONE #>> Amerigroup Correspondence/Appeals P.O. Box 61599 Virginia Beach, VA 23466-1599
Disease Management Referrals	**Amerigroup Disease Management** Phone: <<1-888-830-4300>> TTY: <<711>> Hours: Monday to Friday, <8:30 a.m.-5:30 p.m.> Central time Fax: <<1-888-762-3199>>
Medical Claim Refunds:	Amerigroup Iowa, Inc. P.O. Box 933657 Atlanta, GA 31193-3657
Credentialing and Recredentialing	Phone: <<1-855-789-7989>> Hours: <hours> Email: <iowamedicaid@amerigroup.com>
Provider Services	Phone: <<1-800-454-3730>> Hours: Monday to Friday, 7:30 a.m.-6 p.m. Central time Website: <providers.amerigroup.com/ia>
Fraud and Abuse Department	**Amerigroup Provider Services** Phone: <<1-800-454-3730>> Hours: Monday to Friday, 7:30 a.m.-6 p.m. Central time Fax: <<INSERT PHONE #>>
Grievances and Appeals Department (Provider)	For provider grievances and appeals, including claims, contact: **Amerigroup Provider Services** Phone: <<1-800-454-3730>> Hours: Monday to Friday, 7:30 a.m.-6 p.m. Central time Fax: <<INSERT PHONE #>>

If you have questions about. . .	Contact
Hospital/Facility Admission Notification	**Amerigroup Medical Management** Phone: <<1-800-454-3730>> TTY: 711 Hours: Monday to Friday, 7:30 a.m.-6 p.m. Central time Fax: <<Insert phone #>>
Interpreter Services	**Amerigroup Member Services** Phone: <<1-800-600-4441>> TTY: <<711>> Hours: 24 hours a day, 7 days a week
Amerigroup On-Call	**Amerigroup On Call** Phone: <<INSERT PHONE #>> TTY: <<711>> Hours: 24 hours a day, 7 days a week
Medical Management	Phone: <<1-800-454-3730>> TTY: 711 Hours: Monday to Friday, <7 a.m.-5 p.m.> Central time Fax: <<INSERT PHONE #>>
Member Services	For Member Services, Member Grievances and Appeals, Interpreter Services and personal information changes: Phone: <<1-800-600-4441>> TTY: <<711>> Hours: Monday to Friday, <7:30 a.m.-6 p.m.> Central time After hours, call Amerigroup On Call: <<INSERT PHONE #>> TTY: <<711>> Hours: 24 hours a day, 7 days a week Written correspondence: Amerigroup Iowa, Inc. Central Appeals Processing P.O. Box 62429 Virginia Beach, VA 23466-2429

If you have questions about. . .	Contact
Member Eligibility	Verify eligibility through either Iowa DHS or Amerigroup: **Iowa state eligibility information** • Phone: <<Insert phone #>> • Automated Voice Response Phone: <<phone number>> • Hours: 24 hours a day, 7 days a week • Website: <<website>> **Amerigroup Provider Services** • Phone: <<1-800-454-3730>> • Hours: Monday to Friday, 7:30 a.m.-6 p.m. Central time • Fax: <<INSERT PHONE #>> • Secure Provider portal on our website
Pharmacy Questions and Prescriptions: Providers	**Express Scripts, Inc.** PA Phone: <<1-855-712-0104>> PA Fax: <<1-800-601-4829>> Hours: Monday to Friday, 7:30 AM – 6:00 PM EST Website: www.express-scripts.com **Amerigroup Pharmacy Department** Phone: 1-800-454-3730 Hours: Monday to Friday, 7:00AM – 7:00 PM CST Website: https://providers.amerigroup.com/ia
Pharmacy Questions and Prescriptions: Members	**Amerigroup Pharmacy** Phone: <<1-800-600-4441>> Hours: Monday to Friday, <7 a.m.-7 p.m.> Central time Website: www.myamerigroup.com
Precertification: Behavioral Health	**Amerigroup Medical Management** Phone: <<1-800-454-3730>> Hours: Monday to Friday, <7:30 a.m.-6 p.m.> Central time All requests may be submitted via the web portal: **providers.amerigroup.com/IA** Inpatient Fax: <<1-877-434-7578>> Outpatient Fax: << 1-866-877-5229>>

If you have questions about. . .	Contact
Precertification: Medical	**Amerigroup Medical Management** Phone: <<1-800-454-3730>> TTY: <<711>> Hours: Monday to Friday, <7:30 a.m.-6 p.m.> Central time Fax: <<INSERT PHONE #>>
Precertification: Pharmacy	**Express Scripts, Inc.** Providers: • Phone: <<1-855-712-0104>> • Fax: <<1-800-601-4829>> • Hours: Monday to Friday, <7 a.m.-6 p.m.> Central time Website (providers): www. express-scripts.com
Provider Services Call Center	For Provider Advocate Services, Verifying Eligibility and Benefits, Checking Claims Status and EDI information: Phone: <<1-800-454-3730>> Hours: Monday to Friday, 7:30 a.m.-6 p.m. Central time Fax: <<INSERT PHONE #>>
Transportation Services (Nonemergent)	**<<LogistiCare>>** Phone: <<INSERT PHONE #>> TTY: <<711>> Hours: Monday to Friday, <7 a.m.-6 p.m.> Central time
Vision Services	**Superior Vision Benefit Management, Inc.** Provider Services phone: <<1-866-819-4298>> Member Services phone: <<1-800-679-8901>> TTY: <<711>> Hours: Monday to Friday, <7:30 a.m.-6 p.m.> Central time Website: www.superiorvision.com

CHAPTER 4: COVERED AND NONCOVERED SERVICES

Provider Services **<<1-800-454-3730>>**
Provider Services Fax: **<<INSERT PHONE #>>**
Hours of Operation: **Monday to Friday, <7:30 a.m.-6 p.m.> Central time**

Covered and Noncovered Services

Covered Services

The following grids list the Medicaid covered services, including notations for services requiring precertification. Because covered benefits periodically change, verify coverage before providing services

Covered and Noncovered Services

Covered Services: Medicaid Services

Covered services	Coverage limits
Abortions	May only be approved under the following situations: • If the pregnancy is the result of an act of rape or incest. • In the case where a woman suffers from a physical disorder, physical injury or physical illness, including a life-threatening physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.
Allergy testing and injections	As medically necessary
Anesthesia	As medically necessary
B3 services	Must meet American Society of Addiction Medicine (ASAM) criteria as the utilization management guidelines for substance use disorder residential treatment
Bariatric surgery	As medically necessary
BHIS (including ABA)	As medically necessary
Breast reconstruction	As medically necessary
Breast reduction	As medically necessary
Cardiac rehabilitation	As medically necessary
Chemotherapy	As medically necessary
Chiropractic care (therapeutic adjustive manipulation)	Covered services include: • X-ray payment for documenting X-rays, limited to one per condition • Chiropractic manipulative therapy, limited to the manual manipulation of the spine for the purpose of correcting a subluxation demonstrated by X-ray; there are three categories based off the patient's condition/diagnosis:* — Category I – generally required short-term treatment of 12 per 12-month period — Category II – generally required moderate-term treatment of 18 per 12-month period — Category III – generally required long-term treatment

Covered services	Coverage limits
	of 24 per 12-month treatment post-cancer treatment **For diagnostic combinations between categories, 28 treatments are generally required per 12-month period.*
Colorectal cancer screening	As medically necessary
Congenital abnormalities correction	As medically necessary
Diabetes equipment and supplies	As medically necessary
Diagnostic genetic testing	As medically necessary
Dialysis	As medically necessary
Durable medical equipment (DME) and supplies (DMS)	Covered services include:* • Medical supplies, up to a three-month supply • Diabetic supplies as follows: — Preferred meters/test strips covered under the pharmacy benefit — Blood glucose test or reagent strips - six units per month (One unit equals 50 strips) — Urine glucose test strips - three units per month (One unit equals 100 strips) — Lancets – Four units per month (One unit equals 100 lancets) — Needles – 500 units per month (One unit equals one needle) — Reusable insulin pens are allowed once every six months — Diapers and disposable under pads (can be provided in a 90-day period) ▪ Diaper/brief – one, 80 per 90-day period ▪ Liner/shield/guard/pad – 450 per 90-day supply ▪ Pull-on – 450 per 90-day supply ▪ Disposable under pads – 600 per 90-day supply ▪ Reusable under pads – 48 per 12 months

Durable medical equipment (DME) and supplies (DMS) - Continued	• Hearing aid batteries – up to 30 batteries per aid in a 90-day period
	• Ostomy supplies and accessories – one unit per day of regular wear or three units per month of extended wear
	• No payment is made for medical supplies or durable medical equipment for members for whom the facility is receiving skilled nursing care payment, except for orthotic and prosthetic services, orthopedic shoes, and therapeutic shoes for diabetics.
	• No payment is made for durable medical equipment or supplies for members
	• In an intermediate care facility for intellectual disability or a facility receiving
	• Nursing facility payments, except for the following:
	  • Catheter (indwelling foley)
	  • Colostomy and ileostomy appliances
	  • Colostomy and ileostomy care dressings, liquid adhesive, and adhesive
	  • Tape
	  • Diabetic supplies (disposable or retractable needles and syringes, Test-tape, clinitest tablets, and clinistix)
	  • Disposable catheterization trays or sets (sterile)
	  • Disposable bladder irrigation trays or sets (sterile)
	  • Disposable saline enemas (sodium phosphate type, for example)
	  • Hearing aid batteries
	  • Orthotic and prosthetic services, including augmentative communication devices
	  • Orthopedic shoes
	  • Repair of member-owned equipment
	  • Oxygen services: Oxygen services for residents in an ICF/ID are included in the per diem and are not payable separately.
	  • Assistive Technology

Emergency room services	As medically necessary
Early and periodic screening, diagnosis and treatment (EPSDT)	As medically necessary
Family planning services	As medically necessary
Foot care	As medically necessary
General inpatient hospital care	As medically necessary
Genetic counseling	As medically necessary
Gynecological exams	As medically necessary
Hearing aids	As medically necessary

Hearing exams	Prior approval is required to replace a hearing aid less than four years old unless the member is a child under age 21.
Home health	Covered services include: • Skilled nursing care – limited to five visits per week • Home health aide – limited to 28 hours per week • Occupational, physical and speech therapy – limited to physician-approved visits within rules for restorative maintenance or trial therapy
Hospice	As medically necessary
ICF/ID	Must meet level of care criteria
Imaging/diagnostics (MRI, CT, PET)	As medically necessary
Immunizations	As medically necessary
Infertility diagnosis and treatment	As medically necessary
Inhalation therapy	As medically necessary
Inpatient physician services	As medically necessary
Inpatient surgical services	As medically necessary
IV infusion services	As medically necessary
Lab tests	As medically necessary
Maternity and pregnancy services	As medically necessary
Medical transportation	As medically necessary
Mental health/behavioral health outpatient treatment	As medically necessary
Midwife services	As medically necessary
Nonemergency medical transportation (NEMT)	As medically necessary
Newborn child coverage	As medically necessary
Noncosmetic reconstructive surgery	As medically necessary
Nursing facility	Must meet level of care criteria
Nursing services	Covered services include private duty nursing and personal care services under EPSDT as provided through a home health agency for up to 16 hours per day.
Nutritional counseling	As medically necessary
Occupational therapy (OT)	Medicaid-covered services include services provided by an independently practicing occupational therapist up to the therapy cap as known by the Centers for Medicare & Medicaid Services (CMS). The allowed Medicare Part B outpatient therapy cap for OT is $1,920.
Orthotics	Payment of orthopedic shoes and inserts and therapeutic shoes for members with diabetes are covered as follows: • Two pairs of depth shoes per member in a 12-month period • Three pairs of inserts, plus non-customized removable inserts provided with depth shoes in a 12-month period • Two pairs of custom-molded shoes per member in a 12-month period, plus two additional pair of inserts for custom-molded shoes in a 12-month period

Outpatient surgery	As medically necessary
Pathology	As medically necessary
Pharmacy	• Prior approval is required as stated in the preferred drug list at www.iowamedicaidpdl.com • Reimbursement is only for drugs marketed by manufacturers with a signed rebate agreement • 72-hour emergency supply; this does not apply to medicines to help quit smoking or for hepatitis C • Certain nonprescription over-the-counter (OTC) drugs and nondrugs are covered • Quantities covered includes: ○ Up to a 31-day supply at a time, except certain contraceptives, which is at 90 days ○ OTC drugs – a minimum of 100 units per prescription, or currently available consumer package ○ Initial 15-day supply limit for certain drugs ○ Monthly quantity limit for certain drugs **Noncovered drug categories include:** • Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act • Drugs used for anorexia, weight gain or weight loss • Drugs used for cosmetic purposes or hair growth • Outpatient drugs, if the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased only from the manufacturer or the manufacturer's designee • Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (drugs identified through the Drug Efficacy Study Implementation (DESI) review)). • "Covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any "Part D eligible individual" as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including a member who is not enrolled in a Medicare Part D plan. • Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility • Drugs used for sexual or erectile dysfunction

Pharmacy (Continued	• Drugs for symptomatic relief of cough and colds, except listed nonprescription drugs • Only certain nonprescription (OTC) drugs and non-drugs are covered as listed in 441 Iowa Administrative Code § 78.2(5) and at http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/nonprescription-drugs/2011-11-09/otclistbythercategory20111101.pdf And http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/2014-12-12/Non-Drug%20Product%20List%20Effective%201-1-15.pdf. • Quantity: up to 31 day supply at a time except contraceptives at 90 day; otcs at minimum quantity of 100 units per prescription or currently available consumer package. Some drugs are limited to an initial 15 day supply, list at: http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/quantity-limits/2014-11-24/15-days-supply-list-effective-01-01-15.pdf • Monthly quantity limits by drug list at: http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/quantity-limits/2014-11-24/quantity-limits-list-1-1-15.pdf • Reimbursement at lower of Iowa AAC (WAC if no AAC), FUL or U&C.

Pharmacy (Continued)	• Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and the same, similar or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (Drugs identified through the Drug Efficacy Study Implementation (DESI) review) • Covered Part D drugs as defined by 42 U.S.C. Section 1395 w-102(e)(1)-(2) for any Part D- eligible individual as defined by 42 U.S.C. Section 1395w-101(a)(3)(a), including a member who is not enrolled in a Medicare Part D plan. • Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility • Drugs used for sexual or erectile dysfunction Drugs for symptomatic relief of cough and colds, except listed OTC drugs
Physical therapy	Total Medicaid payment for services from an independent practicing physical therapist shall not exceed the therapy limit as disclosed by the CMS. The legal Medicare Part B outpatient therapy cap for physical therapy is $1,920. This cap may be exceed when medically necessary.
Psychiatric Medical Institutions for Children (PMIC)	As medically necessary
Primary care illness/injury physician services	As medically necessary
Prostate cancer screening	As medically necessary
Prosthetics	As medically necessary
Pulmonary rehabilitation	As medically necessary
Radiation therapy	As medically necessary
Screening Pap test	As medically necessary
Screening mammography	As medically necessary
Second surgical option	As medically necessary
Skilled nursing services	As medically necessary
Sleep studies	As medically necessary
Special physician services	As medically necessary
Speech therapy	Total Medicaid payment for services from an independently practicing speech therapist shall not exceed the therapy limit as disclosed by the CMS. The legal Medicare Part B outpatient therapy cap for speech therapy is $1,920.
Substance use disorder inpatient treatment	Must meet American Society of Addiction Medicine (ASAM) criteria as the utilization management guidelines for substance use disorder services
Substance use disorder outpatient treatment	Must meet American Society of Addiction Medicine (ASAM) criteria as the utilization management guidelines for substance use disorder services
TMJ treatment	As medically necessary
Tobacco cessation	As medically necessary

Tobacco cessation for pregnant women	As medically necessary
Transplant – organ and tissue	As medically necessary
Urgent care centers/facilities **Emergency clinics (nonhospital based)**	As medically necessary
Vision care exams	Routine eye exams are covered once in a 12-month period
Vision frames and lenses	Frame services, single vision lens and multifocal lens services are covered: • Up to three times for children up to age 1 • Up to four times per year for children ages 1-3 • One frame every 12 months for children ages 4-7; safety frames are covered for children through age 7 • One frame every 24 months for members age 8 and older Gas permeable contact lenses are covered: • Up to 16 lenses for children up to age 1 • Up to eight lenses every 12 months for children ages 1-3 • Up to six lenses every 12 months for children ages 4-7 • Two lenses every 24 months for members age 8 and older Replacement of lost or damaged glasses beyond repair are covered: • For adults age 21 and older, once every 12 months • For children younger than age 21 are not limited
Walk-in center services	As medically necessary
X-rays	As medically necessary

Covered and Noncovered Services

Covered Services: hawk-I Program

Covered services	Coverage limits
Inpatient hospital services	Covered services include: • Medical • Surgical • Intensive care unit • Mental health • Substance abuse
Physician services	Covered services include: • Surgical • Medical • Office visits • Newborn care • Well-baby care • Well-child care • Immunizations • Urgent care • Specialist care • Allergy testing and treatment • Mental health visits • Substance use visits
Outpatient hospital services	Covered services include: • Emergency room • Surgery • Lab • X-ray • Other services
Ambulance services	As medically necessary
Physical therapy	As medically necessary
Nursing care services	Covered services include skilled nursing facility services
Speech therapy	As medically necessary
Durable medical equipment	As medically necessary
Home health care	As medically necessary
Hospice services	As medically necessary
Prescription drugs	As medically necessary
Hearing services	As medically necessary
Vision services	Covered services include corrective lenses

Covered and Noncovered Services

Non-Covered Services: hawk-I Program

Not Covered Services

EPDST services	
PMIC or residential care	
Acupuncture	
Cosmetic Procedures	
Counseling and Education Services	
Custodial Care	
Orthotics	Not covered arch supports, or in-shoe supports, orthopedic shoes, elastic support, or examinations to prescribe or fit such devices

Covered and NonCovered Services

Covered Services: Iowa Wellness Plan Benefits

Covered services	Coverage limits
Ambulatory services	
Primary care illness/injury Physician services	As medically necessary
Specialty physician visits	As medically necessary
Home health services	These services are not covered: • Private duty nursing • Personal care • Not covered: Procedure codes S9122 or REV codes 570 or 571
Chiropractic care: therapeutic adjustive manipulative	As medically necessary
Outpatient surgery	As medically necessary
Second surgical opinion	As medically necessary
Allergy testing and injections	As medically necessary
Chemotherapy: outpatient	As medically necessary
IV infusion services	As medically necessary
Radiation therapy: outpatient	As medically necessary
Dialysis	As medically necessary
Anesthesia	As medically necessary
Walk-in centers	As medically necessary
AIDS/HIV parity	As medically necessary
Access to clinical trials	Medical necessity will be decided on a case-by-case basis through the prior approval process.
Genetic counseling	• Prior authorization required. Must be an appropriate candidate and outcome is expected to determine a covered course of treatment and not just informational.

Emergency services	
Emergency room services	As medically necessary
Emergency transportation-ambulance and air ambulance	Reviewed for medical need prior to payment
Urgent care centers/facilities Emergency clinics(nonhospital)	As medically necessary
Hospitalization	
General inpatient hospital care	As medically necessary
Inpatient physician services	As medically necessary
Inpatient surgical services	As medically necessary
Noncosmetic reconstructive surgery	As medically necessary
Transplant organ and tissue	Covered services include: • Certain bone marrow/stem cell transfers from a living donor • Heart • Heart/lung • Kidney • Liver • Lung • Pancreas • Pancreas/kidney • Small bowel Noncovered services include: • Transport of living donor • Services/supplies related to mechanical or nonhuman organs • Transplant services and supplies not listed in this section, including complications
Congenital abnormalities correction	As medically necessary
Anesthesia	As medically necessary
Hospital care – inpatient	As medically necessary
Hospice respite – inpatient	Limited to 15 days per lifetime for inpatient respite care. 15 days per lifetime for outpatient hospice respite care. Hospice respite care must be used in increments of not more than 5 days at a time.As medically necessary
Chemotherapy – inpatient	As medically necessary
Radiation therapy – inpatient	As medically necessary
Breast reconstruction	As medically necessary
Maternity and newborn care	
Maternity/pregnancy services – prenatal and postnatal care – delivery and inpatient maternity –nutritional	Member is required to report: • Pregnancy • Eligibility for consideration of benefits under the Medicaid state plan
Tobacco cessation for pregnant women	As medically necessary
Midwife services	As medically necessary
Newborn child coverage	As medically necessary
Mental health/behavioral health/substance abuse disorder	

Mental health/behavioral health inpatient treatment	Those with disabling mental disorders will be considered medically exempt and enrolled in the Medicaid state plan. Residential treatment is not covered
Mental health/behavioral health outpatient treatment	Those with disabling mental disorders will be considered medically exempt and enrolled in the Medicaid state plan. Residential treatment is not covered.
Substance use disorder inpatient treatment	Those with disabling substance use disorder will be considered medically exempt and enrolled in the Medicaid state plan. Residential treatment is not covered. Not covered: Code H0019
Substance use disorder outpatient treatment	Those with disabling substance use disorder will be considered medically exempt and enrolled in the Medicaid state plan.
Prescription drugs	
Prescription drugs	• As medically necessary
Rehabilitative and habilitative services and devices	
Physical therapy, occupational therapy and speech therapy	Covered services include: • 60 visits per year for each therapy • Occupational therapy for upper extremities Noncovered services include: • Occupational therapy supplies • IP occupational therapy and physical therapy, in the absence of a separate medical condition requiring hospitalization

Inhalation therapy	Limit of 60 visits in a 12-month period
Medical and surgical supplies	Noncovered services include: Elastic stockings, orBandages, including trusses, lumbar braces, garter belts and similar items that can be purchased without a prescription (supplies covered if written prescription provided)
Durable Medical Equipment	Noncovered services include: • Elastic stockings, or Bandages, including trusses, lumbar braces, garter belts and similar items that can available for purchased without a prescription
Orthotics	As medically necessary
Prosthetics	As medically necessary
Cardiac rehabilitation	As medically necessary
Pulmonary rehabilitation	As medically necessary
Skilled nursing services	These services are covered in: • Nursing facilities • Skilled nursing facilities • Hospital swing beds • Limited to 120 days per 12 month period
Laboratory services	
Lab tests	As medically necessary
X-rays	As medically necessary
Imaging/diagnostics: MRI/CT/PET	As medically necessary
Sleep studies	• Services must be for a diagnosis of sleep apnea • Treatment for snoring is not covered
Diagnostic genetic testing	Requires prior approval.
Pathology	As medically necessary
Preventive care	
Preventive care	Limited to ACA-required covered services
Nutritional counseling	Max 40 units allowed for 12 months. Not covered: 97802, 97803, G0270
Nutritional counseling	Max 20 units allowed for 12 months. Not covered: 97804 & G0271
Counseling and education services	Noncovered services include: • Bereavement, family or marriage counseling • Education, other than diabetes
Family planning	As medically necessary
Vision care exams (adults)	• Limit of one general ophthalmology service per year This does not limit the medical exams
Immunizations	Immunizations for travel are not covered
Colorectal cancer screening	As medically necessary
Screening mammography	Limit of one screening per year
Hearing exam (adult)	Limit of one hearing exam per year
Diabetes – medically necessary equipment and supplies/education	Preferred meters/test strips are covered under the pharmacy benefit
Screening pap test	As medically necessary
Gynecological exam	One per year
Prostate cancer screening	One per year for men ages 50-64

Foot care	• Care must be related to a medical condition • Routine services are not covered
Tobacco cessation	• Immunizations and medical evaluation for nicotine dependance
Pediatric services, including oral and vision	
Early and periodic screening, diagnosis and treatment (EPSDT)	Oral and vision services are covered for children aged 19-20

Covered and Noncovered Services

Covered Services: Family Planning Covered Services

Family planning services and supplies are limited to those services and supplies that:

- Are provided in a family planning setting
- Have a primary purpose of family planning.

The Iowa DHS Family Planning Services Provider Manual is available at **https://dhs.iowa.gov/sites/default/files/FamPlan.pdf**

Covered services	Coverage limits
Family planning benefits	Family planning services and supplies are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. • Approved methods of contraception; • Sexually transmitted infection (STI) or sexually transmitted disease (STD) testing, Pap smears and pelvic exams; • Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider; and • Contraceptive management, patient education, and counseling. The laboratory tests done during an initial family planning visit for contraception may include a Pap smear, screening tests for STIs or STDs, or pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.

Family planning-related benefits	"Family planning-related services and supplies" are defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the state's regular federal medical assistance percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was defined or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies include:

Family planning-related benefits (Continued)	• Colposcopy and procedures done with or during a colposcopy or repeat Pap smear performed as a follow-up to an abnormal Pap smear that was done as part of a routine periodic family planning visit.
	• Drugs for the treatment of STIs or STDs, except for HIV/AIDS and hepatitis, when the STI or STD is identified or diagnosed during a routine periodic family planning visit. A follow-up visit or encounter for the treatment or drugs and subsequent follow-up visits to rescreen for STIs or STDs based on the Centers for Disease Control and Prevention guidelines may be covered.
	• Drugs or treatment for vaginal infections or disorders, other lower genital tract and genital skin infections or disorders, and urinary tract infections, where these conditions are identified or diagnosed during a routine periodic family planning visit. A follow-up visit or encounter for the treatment or drugs may also be covered.
	• Other medical diagnosis, treatment, and preventative services that are routinely provided pursuant to family planning services in a family planning setting.
	• Treatment of major complications arising from a family planning procedure, such as:
	  • Treatment of a perforated uterus due to an intrauterine device insertion;
	  • Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
	  • Treatment of surgical or anesthesia-related complications during a sterilization procedure.

Covered and Noncovered Services

Covered Services: Iowa Department of Public Health Covered Services

Covered services	Coverage limits
Outpatient treatment	As medically necessary
Intensive outpatient treatment	As medically necessary
Partial hospitalization (day treatment)	As medically necessary
Clinically managed low intensity residential treatment	As medically necessary
Clinically managed medium intensity residential treatment	As medically necessary
Clinically managed high intensity residential treatment	As medically necessary
Medically monitored intensive inpatient treatment	As medically necessary
Intake assessment and diagnosis services	Covered services include: • Appropriate physical exam • Urine screening • All needed medical testing to: — Decide a substance abuse disorder diagnosis — Identification of a medical or health problems — Screen for contagious diseases
Evaluation, treatment planning and service coordination	As medically necessary
Substance abuse treatment services	Services vary based on the level of service and may include but are not limited to: • Physician, physician assistant, psychologist, nurse, certified addictions counselor, social worker and trained staff services • Rehabilitation therapy and counseling • Family counseling and intervention for the primary recipient of services, including codependent /collateral counseling with primary recipient of services • Diagnostic X-ray, specific to substance abuse treatment • Diagnostic urine testing, specific to substance abuse treatment • Psychiatric, psychological and medical lab testing, specific to substance use disorder treatment • Equipment and supplies • Cost of prescription drugs
Substance abuse counseling services through approved opioid treatment programs licensed under Iowa Code Chapter 125	Cost of buprenorphine and methadone dispensing will not be covered.
Substance abuse treatment for IDPH (Iowa Department Of Public Health) participants	As medically necessary

whose driving licenses or nonresident operating privileges are revoked under chapter 321J, provided that such treatment services meets the criteria for service necessity and sliding fee scale.	
Court-ordered evaluation for substance abuse	As medically necessary

Covered and Noncovered Services
Home and Community Based Services (HCBS)

Covered services	Coverage limits
1915 (c) services • AIDS/HIV • Brain Injury • Children's Mental Health • Elderly • Health and Disability • Intellectual Disability • Physical Disability	Must meet Home and Community-Based waiver eligibility level of care criteria: Providers may reference the IME's Home and Community Based Services (HCBS) Provider Manual at **https://dhs.iowa.gov/sites/default/files/HCBS.pdf** for required covered services and minimum coverage limits.
1915 (i) habilitation services	Must meet Habilitation waiver eligibility level of care criteria

Covered and Noncovered Services
Covered Services: Value-Added Services

(PENDING STATE APPROVAL)

Amerigroup believes by offering expanded programs and services, we provide opportunities to help care for the whole person and better address the specific needs for each segment of the population. To help care for the whole person and address the specific needs for each population segment, Amerigroup has developed benefits that will enhance care, promote healthier outcomes, and increase member satisfaction.

For a description of the Value Added Services – please see Appendix A in the back of this manual.

Health and Wellness Service

- Tobacco cessation counseling
- Waived co-pays for specific services
- Weight Watchers® class vouchers
- Personal exercise kit
- Healthy Families nutrition and fitness program
- Boys and Girls Club® membership
- Oral hygiene kit
- Home delivered meals
- Post-discharge stabilization kit

Training and Supports Services

- Amerigroup Community Resource Link
- High School Equivalency Test (HiSet®) assistance
- Personal backpack
- Comfort item
- Financial management support
- Self-advocacy memberships
- Travel training

Supported employment**Independent Living Skills Services**

- Additional personal care attendant supports
- Additional respite care services
- Transportation assistance
- Assistive devices
- Additional phone minutes through Safelink®
- Durable medical equipment and supplies
- Community reintegration benefit

Covered and NonCovered Services

Covered Services: Healthy Rewards Program

(PENDING STATE APPROVAL)

The Amerigroup Healthy Rewards program rewards members for doing things that are good for their health. Members can earn [$5, $10, $15, $20 or $25] for their efforts to stay healthy. Every time a member completes one of the healthy activities, they'll get dollars added to their Healthy Rewards card.

Members can spend these Healthy Rewards dollars at [Family Dollar], [Dollar General], [Fred's Super Dollar] and [Rite Aid] stores near them on a variety of approved items they need to stay healthy. The table below lists all of the healthy activities a member may qualify for.

Incentive	Population	Individual amount	Limits
For all members			
Complete the new member Health Risk Screening Tool within 90 days of enrollment with Amerigroup	All members	$20	One per member
For members with Asthma			
Obtain appropriate asthma medicines	Ages 5-64	$10	Once per member
For children			

Incentive	Population	Individual amount	Limits
Complete well-child visits within the first 15 months of life	0-15 months	$10	Six within first 15 months of life
Complete annual EPSDT visits	Ages 2-21	$20	Once every 12 months
Obtain 1 capillary or venous lead screening test	Under age 2	$10	Once per member
Obtain 4 diphtheria-tetanus-acellular pertussis (DTAP); 3 polio (IPV); 1 measles, mumps and rubella (MMR); 3 H influenza type B (HiB); 3 hepatitis B (HepB); 1 chicken pox (VZV); 4 doses of pneumococcal conjugate (PCV); 1 hepatitis A (HepA); 2 or 3 rotavirus (RV); and 2 influenza (flu) vaccines	When turning age 2	$10	Once per member
Obtain 1 dose of meningococcal vaccine, and 1 tetanus, diphtheria toxoids, acellular pertussis vaccine (Tdap) or 1 tetanus, diphtheria toxoids vaccine (Td)	When turning age 13	$10	Once per member
For children with attention deficit hyperactivity disorder (ADHD)			
Complete one follow-up visit with prescribing practitioner within 30 days of initial prescription for ADHD	Ages 6-12	$10	Once per new prescription
Complete two visits with prescribing practitioner between 31 and 270 days of initial prescription for ADHD	Ages 6-12	$10	Once per new prescription
Continued use of ADHD medicine for at least 210 days	Ages 6-12	$10	Once per new prescription
For members with diabetes (excluding gestational diabetes)			
Complete Blood sugar test (A1c)	Ages 18-75 with diabetes	$30	Once every 12 months

Incentive	Population	Individual amount	Limits
Complete Cholesterol (LDL) test	Ages 18-75 with diabetes	$30	Once every 12 months
Complete Nephropathy test	Ages 18-75 with diabetes	$30	Once every 12 months
Complete Eye Exam	Ages 18-75 with diabetes	$30	Once every 12 months
For women			
Complete breast cancer screening	Ages 50-74	$30	Once every 24 months
Complete cervical cancer screening	Ages 21-65	$30	Once every 36 months
Complete first prenatal care visit during 1st trimester or within 42 days of enrollment	Pregnant women	$25	Once per pregnancy
Complete postpartum visit between 21 and 56 days after delivery	Pregnant women	$50	Once per pregnancy
For members who use tobacco (with 11 months of Amerigroup enrollment)			
Fill prescribed smoking cessation medicines	Age 11 and older	$30	Once per member
Participate in the Amerigroup Smoking Cessation Program or Iowa's Tobacco Quit Line	Age 11 and older	$30	Once per member
For members with behavioral health diagnosis			
Continue use of antidepressant medicine for at least 84 days	Age 18 and older	$10	Once per new prescription
Continue use of antidepressant medicine for at least 180 days	Age 18 and older	$10	Once per new prescription
Complete diabetes screening (glucose of HbA1c) test when prescribed an antipsychotic medicine for schizophrenia and/or bipolar disorder	Ages 18-64	$10	Once every six months

Incentive	Population	Individual amount	Limits
Remain on antipsychotic medication for at least 80 percent of treatment period if diagnosed with schizophrenia	Ages 19-64	$10	Once per prescription
For long-term services and support (LTSS) Members			
Complete LTSS assessment within 90 days of LTSS enrollment	LTSS members	$20	Once per member
Complete LTSS educational module as recommended by LTSS community-based case manager	LTSS members	$20 per module	Once per member

Covered and Noncovered Services

State-Covered Services

Some services are covered by the state instead of Amerigroup. These services are labelled as *carved-out services*. Although Amerigroup does not cover these services, providers and specialists must provide all required referrals and assist in setting up these services. These services include:

- Services included in the PACE program
- Dental services provided outside of a hospital setting
- MFP grant services
- Services provided in an Iowa Veteran's Home
- School-based services provided by the areas education agencies or local education agencies
- Services for members over the age of 21 and under the age of 65 in a state mental institution.

For details on how and where to access these services, members can call the [Iowa Medicaid Enterprise Member Services Unit] toll free at [1-800-338-8366, Monday through Friday from 8 a.m. to 5 p.m. Central time].

Covered and NonCovered Services

NonCovered Services

Amerigroup does not cover the following services:

- Care provided outside the United States, Canada and Mexico, including emergency services. Amerigroup reimburses for emergency services provided to members in Canada or Mexico; however, payment for such services must be made to a financial institution or entity located within the United States. Nonemergency services in Canada or Mexico may be covered by Amerigroup per precertification policies, provided the financial institution receiving payment is located within the United States.
- Cosmetic surgery, including tattoo removal and ear lobe repair
- Experimental or investigational procedures

- Services that are not medically necessary
- Sex change surgery or treatments
- Surgery or drugs to enhance fertility

Noncovered services also include any instance when the precertification for a service was not granted, or the service was provided before precertification was given.

Covered and Noncovered Services

Services Requiring Precertification

Services requiring precertification include, but are not limited to:

- Air ambulance
- Behavioral health (all inpatient, some outpatient services, in-home therapy services and psychological testing require precertification; for specialist referrals and precertification call: <<1-800-454-3730>>)
- Circumcision (Amerigroup covers routine circumcision without authorization up to 12 months of age. After 12 months of age, medical necessity review is required)
- Durable medical equipment (DME) and durable medical supplies (DMS)
- Genetic testing (except routine amniocentesis and prenatal testing)
- Home health care services
- Hyperbaric oxygen therapy (no coverage for use of equipment)
- Infusion/injection therapy
- Inpatient hospital services
- Inpatient surgeries and procedures
- Outpatient surgeries and procedures
- Pharmacy
- Physician services (referrals to out-of-network specialists require precertification)
- Radiology services
- Spinal surgeries (lumbar fusion, disc excision and decompression surgery)
- Therapy services, including physical, occupational and speech therapies
- Transplant services
- Vision (most routine vision services do not require precertification. If you have questions or need clarification, call Superior Vision Provider Services at <<1-866-819-4298>>.

For information concerning precertification select the **Precertification** tab on the left side of our Providers page at **providers.amerigroup.com/ia.**

Covered and Noncovered Services

Dental ServicesAmerigroup covers all medically necessary charges related to dental procedures provided in a hospital setting. Dental service provider outside of a hospital setting are covered by the Iowa Dental Program. Professional services provided both inside and outside of a hospital setting is the responsibility of the State Dental Program.

Coverage	Dental Services	Contact Number
Dental Service	**Dental services provided outside of a hospital setting**	<414-389-9880> TTY: 711

Covered and Noncovered Services

Vision Services

Amerigroup contracts with Superior Vision Care to provide covered routine and emergency vision services. Amerigroup covers the following services when performed by a Superior Vision Care-contracted provider or with precertification from Superior Vision Care by an out-of-network provider:

- Emergency vision services (immediately if trauma or eye conditions have turned to life-threatening conditions)
- Routine vision services

To arrange for vision services, call Superior Vision Care at <<1-866-819-4298>> for Provider Services and <<1-800-679-8901>> for Member Services.

Covered and Noncovered Services

Nonemergency Transportation Services

Nonemergency transportation is a benefit managed by **Logisticare** for Amerigroup members enrolled in Iowa Medicaid. These services include bus and taxi rides for members needing help getting to medical appointments, as well as special vehicle transportation for Amerigroup members in wheelchairs. Members should schedule nonemergency transportation a minimum of three days in advance.

Phone: <<INSERT PHONE #>>

CHAPTER 5: Long Term Services and Supports

Long Term Services and Supports
Overview

Amerigroup's fundamental approach to long term services and supports (LTSS) is founded on person-centered principles and practices to facilitate member and family driven services and supports that are responsive and meaningful to evolving preferences, support needs, and personal goals. We are dedicated to assisting all members in exploring service and support options to maximize community integration in alignment with their personal goals and the Olmstead Decision. Through this commitment, not only do we support members to succeed in communities of their choice, we also partner with providers, stakeholders and associations.

Iowa has seven Home and Community Based Services (HCBS) waiver programs. The waiver programs are:

- AIDS/HIV waiver
- Brain injury waiver
- Children's mental health waiver
- Elderly waiver
- Health and disability waiver
- Intellectual disability waiver
- Physical disability waiver

More information on each waiver program follows.

Long Term Services and Supports
Waiver Descriptions

AIDS/HIV Waiver

The AIDS/HIV waiver offers services for those who have been diagnosed with AIDS or HIV, such as:

- Adult day care
- Consumer-directed attendant care (CDAC)
- Counseling services
- Home-delivered meals
- Home Health aide
- Homemaker
- Nursing
- Respite

Brain Injury Waiver

The Brain Injury waiver offers services for those that have been diagnosed with a brain injury Members must be aged from one month, there is no age maximum for this waiver. Services include:

- Adult day care
- Behavioral programming
- Case management
- CDAC
- Family counseling and training
- Home and vehicle modification
- Interim medical monitoring and treatment
- Personal emergency response
- Prevocational services
- Respite
- Specialized medical equipment
- Supported community living

- Supported employment
- Transportation

Children's Mental Health Waiver

The Children's Mental Health waiver offers services for children who have been diagnosed with serious emotional disturbance. These are the services that members may receive if there is a need for this waiver:

- Environmental modifications and adaptive devices
- Family and community support services
- In-home family therapy
- Respite

Elderly Waiver

The Elderly waiver provides services for elderly persons. Individuals must be at least 65 years of age for this waiver. Some of the services that members may receive if there is a need include:

- Adult day care
- Assistive devices
- Assisted living
- Case management
- Chore Assistance
- Consumer-directed attendant care (CDAC)
- Home and vehicle modification
- Home-delivered meals
- Home Health aide
- Homemaker
- Mental health outreach
- Nursing
- Nutritional counseling
- Personal emergency response
- Respite
- Senior companion
- Transportation

Health and Disability Waiver

The Health and Disability waiver provides services for persons who are blind or disabled. The services that a member may receive if there is a need include:

- Adult day care
- Consumer-directed attendant care (CDAC)
- Counseling
- Home-delivered meals
- Home Health aide
- Homemaker services
- IMMT
- Home and vehicle modification
- Nursing
- Nutritional counseling
- Personal emergency response
- Respite

Intellectual Disability Waiver

The Intellectual Disability waiver provides services for persons who have been diagnosed with intellectual disability or a mental disability equivalent to intellectual disability as determined by a psychologist or psychiatrist. These are the services that a member may receive if there is a need for this waiver:

- Adult day care
- Personal emergency response
- Consumer-directed attendant care (CDAC)
- Prevocational services
- Day habilitation
- Respite services
- Home and vehicle modification
- Supported community living
- Home Health aide
- Supported community living-residential based

- Interim medical monitoring and treatment
- Supported employment
- Nursing
- Transportation

Physical Disability Waiver

The Physical Disability waiver provides services for persons who have a physically disability determination. An applicant must be at least 18 years of age, but less than 65 years of age. These are the services that a member may receive if there is a need for this waiver:

- Consumer-directed attendant care (CDAC)
- Home and vehicle modification
- Personal emergency response
- Specialized medical equipment
- Transportation

Long Term Services and Supports
Precertification Requirements

Precertification, sometimes referred to as prior authorization (PA), is required for all Nursing Facility (NF) / Skilled Nursing Facility (SNF) and LTSS services for which Medicaid is the primary payer, including all levels of care, medical and nonmedical absences, hospice services rendered in an NF/SNF and reserve days (leaves of absence). The hospice provider is responsible for obtaining precertification and is required to pay the NF and NF/SNF room and board charges.

Providers must submit precertification requests with all supporting documentation immediately upon identifying an SNF admission or at least 72 hours prior to the scheduled admission.

So we can ensure appropriate discharge planning, you must provide notice to Amerigroup via our precertification process when the following events occur:

- Admission to an acute care or behavioral health care facility
- Admission to hospice

For members that enter the facility as "Medicaid Pending", please request a precertification as soon as the state approves the Medicaid eligibility and the member's eligibility is reflected on the Amerigroup website.

The Amerigroup website and your Provider Manual list those services that require precertification and notification. Our provider website also houses evidence-based criteria we use to complete precertification and concurrent reviews.

The precertification request can be submitted by:

- Faxing the request to <1-XXX-XXX-XXXX>
- Calling Care Management at <1- XXX-XXX-XXXX>
    - For members selecting hospice services, Amerigroup will pay the hospice for the room and board charges, and the hospice will pay the SNF at the current applicable Iowa Medicaid rate.

Providers can obtain the status of a precertification request by visiting our provider website at providers.amerigroup.com/ia.

Long Term Services and Supports
Person-centered Case Management Model

Amerigroup's approach utilizes regional case management teams with multifunctional expertise to assist Community-Based Case Managers, members, families, representatives and members' interdisciplinary teams in the development of person-centered service plans and serve as an ongoing resource to meet the varying needs of members to support health, well-being, independence and community living in the most integrated setting such as employment and participation in community activities. Our case management model involves a continuous process of communicating, coordinating, delivering, monitoring and assessing services and supports and progress toward achieving member goals to optimize person-centered service delivery. The core components of the case management model will include:

- Matching our members to the right Community-Based Case Manager by carefully considering member diagnoses, complexity of medical and/or behavioral health conditions and intensity of service and support

needs, and identifying a Community-Based Case Manager on our team with appropriate experience, knowledge and skills.

- Person-centered planning through partnership and collaboration with members, their natural supports and member-identified interdisciplinary teams who will consider members holistically using discovery and assessment results to make sure that medical, behavioral, social and educational needs are addressed to maximize health, well-being and independence in the development of a comprehensive, person-centered service plan.
- Coordination and collaboration across member systems of care to align resources based on need, integrate services, reduce duplication of efforts, improve continuity of care and services and increase cost efficiencies.
- The continuous process of delivering, monitoring and assessing interventions designed to meet the members' goals defined in person-centered service plans, as well as other care/treatment plans, as part of their system of care to maximize individual health, well-being and quality of life.
- Technology and innovations to improve member and natural support experiences, expand the tools to enable collaboration among multiple stakeholders, enhance our members' ability to self-direct services and supports, provide real-time member information and improve provider and system performance.
- Ongoing stakeholder engagement at the member and system levels to build consensus, innovative solutions related to issues and concerns, and facilitate continuous program improvements to better serve members.

Supporting Member Education and Informed Choices

A core responsibility within our model is embracing person-centered service planning. We communicate an array of options available to our members, supporting and promoting their informed decision-making and their well-being. Our approach promotes member engagement in all aspects of care and services, including interdisciplinary team development, use of supports, and choice of specific providers. From our experience, we know fully informed members make effective decisions that promote health and safety and are suited to their preferences. This is a cornerstone to improving member experience, adherence to the service plans and overall outcomes.

Long Term Services and Supports

Initial Discovery, Assessments and Informed Consent

Once a member has enrolled in our LTSS program, our Community-Based Case Management team contacts the member and begins the educational process regarding our role, program services, benefits, resources and options available to promote integrated coordination. During this conversation, the member receives an overview of the core service planning and case management processes including all applicable assessments. This comprehensive orientation allows us to align with the member on his or her preferences and confirm the member's interest in LTSS.

During face-to-face assessments, we engage members, their interdisciplinary team, member-selected participants, and natural supports, including family, in a highly individualized conversation to identify needs and preferences for building out their service plan. While outlining the benefits included in the LTSS program, we remind members of their right to choose their interdisciplinary team members, case managers and services including the option to self-direct their services through the CCO. If members choose the CCO, we provide training and administrative support to bolster member confidence in self-directing while preventing gaps in services. Amerigroup helps assure that all processes, such as selecting providers and developing a service plan, reflect and honor the member's strengths, goals and preferences.

Long Term Services and Supports
Person-Centered Service Planning

Our Community-Based Case Managers work collaboratively with members to develop a service plan that emphasizes and supports member choice and individual goals. During service plan development, we continuously engage members and their family or representatives about needs and preferences. Our Community-Based Case Managers work with members, their family or representatives and their providers to identify all available services and supports, including but not limited to: covered benefits, community and state agency resources, value-added services, health insurance coverage options (such as Medicare) and natural supports. Our Case Managers reside in the same communities as our members and therefore have detailed knowledge about the community, local provider network, other community resources available, and Medicare, Medicaid, and LTSS benefits. Our Case Managers are also culturally diverse. We train our Case Managers in cultural competency to help assure that members have every opportunity to comfortably express preferences and communicate with their Case Manager.

Long Term Services and Supports
Incorporating Member Choice in Funding Decisions

As members request adjustments to their service plans based on changing circumstances or new information, our Community-Based Case Managers honor their preferences, unless a requested service is unavailable. If a service could potentially pose a health or safety issue or is not a covered benefit, the Community-Based Case Manager will work to educate the member and revise the service plan to address all concerns and preferences. Our Community-Based Case Managers assure that all approved services are consistent with the member's level of care and waiver designation as applicable. We further assure that the member does not exceed his or her established cost limit. Throughout this process, we will put our members' needs and preferences first and will not hesitate to deploy creative strategies to help support our members.

Long Term Services and Supports
Identification

Amerigroup has developed operational protocols, policies and procedures to promote early identification of member service and support gaps that may signal emerging needs that are better addressed through LTSS programs to enhance member health, well-being and independence. All Community-Based Case Managers are trained to recognize indicators that suggest a member may benefit from and meet LTSS program enrollment criteria. Amerigroup will train all Community-Based Case Managers on LTSS eligibility criteria established by Iowa Medicaid Enterprise (IME) so that timely action is taken in coordination with DHS. Our Community-Based Case Managers engage and inform members regarding all available LTSS options. After conducting initial assessments for interested members using a state-approved tool, Amerigroup will refer all potentially eligible members to the state or its designee for level of care determination. Through this process, we are better able to align services and supports with member strengths, needs and preferences to accommodate the periods of transition that all people and families experience.

Long Term Services and Supports

Processing Referrals to LTSS Services

Amerigroup's "no wrong door" approach provides a single point of entry for LTSS program referrals from end to end. All member-facing staff accepts self-referrals from members or referrals from their families, support networks, service providers or health professionals. Training includes respect for the member's own advocacy and self-direction, active listening skills, how to gather situational facts, accurate documentation of essential information for follow-up, and proper routing of requests to the LTSS case specialist or the assigned Case Manager or care coordinator. In each instance, staff will work in consultation with the case management team manager to link the member with a Community-Based Case Manager. The member's Case Manager or care coordinator will work in tandem with the newly assigned Community-Based Case Manager to facilitate continuity and integration of all service and support needs in the process described below. In the event that a member has not been linked to a specific Case Manager or care coordinator, the newly assigned Case Manager will consult and engage team members with relevant expertise throughout the process detailed below:

- Regardless of the referral source, the assigned Case Manager will contact the member and, as appropriate, their family or representative to learn more about the member's needs and concerns. The Case Manager will discuss the request and the required steps prior to LTSS program referral to the state or its designee. If the member has an established relationship with another Case Manager or care coordinator, he or she will facilitate the introductory call. The Case Manager will describe LTSS options and discuss interest in receiving LTSS. During the initial call, the Case Manager will also perform a brief telephonic screening to determine the level of urgency to prioritize both access to services and the face-to-face assessment.
- If it is determined that the member has an urgent need compromising health and safety as a result of a recent change in daily living circumstances or health-related conditions, the Case Manager will authorize medically necessary interim services and schedule and complete a face-to-face screening assessment no later than seven days from the date of referral.
- If the results of the telephonic screening indicate that the need for LTSS is not urgent, the Case Manager will work with the member and as appropriate the family or representative to schedule and complete the face-to-face assessment no later than 30 days from the date of referral. Referrals received after-hours will be routed through our 24/7 member call center. The call center representative will have access to our core operating system and will enter a detailed message that tasks the member's Community-Based Case Manager for follow up with the member the next business day. When indicated, the call center representative will also be able to connect the member to an on-call Community-Based Case Manager after hours.
- For members in crisis, a referral will be made immediately to emergency services. In the event of a medical emergency, our members are encouraged to call 911; our call center representatives will assist as requested to facilitate the call.

Ongoing Identification of Members Who May Be Eligible for LTSS

In addition to processing all inbound referrals, Amerigroup's person-centered approach uses an array of ongoing discovery and assessment strategies to facilitate proactive identification of members who currently need additional resources available through LTSS programs and those with risks factors that signal signs of instability in life circumstances such as physical and/or behavioral health conditions that may result in a change that leads to LTSS eligibility. Our comprehensive approach emphasizes an integrated model that utilizes our collective expertise of our health plan employees and the interdisciplinary team to develop a holistic view of each member's evolving life experiences and service and support needs across physical, behavioral health and social service delivery systems.

Through internal and external collaboration and coordination we are able to maximize available state, regional and community resources to eliminate service and support gaps promoting member health, wellbeing and independence. For example, our physical health, behavioral health and LTSS leadership and teams are co-located to facilitate an internal referral process to address unmet needs. So, as Behavioral Health Case Managers become aware of changing needs with a member, they can consult and refer the member to their LTSS colleagues to provide all needed supports. Additionally, the teams conduct a variety of internal collaborative case rounds to build immediate and long-range solutions for our members with the most complex needs, including integrated rounds for members with co-occurring conditions, complex case rounds for LTSS members with medically fragile conditions and nursing facility reintegration rounds for members we are assisting in repatriating to the community. Our Case Managers navigate delivery systems and coordinate with our state and regional partners, contracted providers and community resources to link members to needed services and supports that are brainstormed through our collaborative processes.

Long Term Services and Supports

Transition and Discharge Planning

When LTSS are necessary, Amerigroup works with the provider and member (or their designated representative) to plan the transition or discharge to an appropriate setting for extended services. These services can be delivered in a nonhospital facility such as:

- Nursing facilities, subacute care facilities (NF/SCF)
- Respite care – in home or out of home
- Home and Community Based Services (HCBS)
- Home health care program (i.e., home I.V. antibiotics)

When the member and family, together with the provider, identifies medically necessary and appropriate services, Amerigroup will assist in providing a timely and effective plan that meets our member's needs and goals.

Discharge Planning

Amerigroup assists with discharge planning, either to the community or through a transfer to another facility, if the member or responsible party so requests. If the member or responsible party requests a discharge to the community, the Care or Service Coordinator will:

- Collaborate with the skilled nursing facility (SNF) social worker to convene a planning conference with the SNF staff to identify all potential needs in the community.
- Facilitate a home visit to the residence where the member intends to move to assess environment, durable medical equipment (DME) and other needs upon discharge.
- Convene a discharge planning meeting with the member and family, using the data complied through discussion with the SNF staff as well as a home visit, to identify member preferences and goals.
- Involve and collaborate with community originations such as Community Developmental Disability Organizations (CDDOs), Centers for Independent Living (CILs) or Area Agencies on Aging (AAAs) in this process to assist members as they transition to the community.
- Finalize and initiate execution of the transition plan.

Although our person-centered approach is driven by the member, the transition implementation is a joint effort between the SNF social worker and the Amerigroup Community-Based Case Manager.

Long Term Services and Supports
Responsibilities of the LTSS Provider

- Assisted living facilities and nursing homes must retain a copy of the member's Amerigroup plan of care on file with the member's records.
- Assisted living facilities are required to promote and maintain a homelike environment and facilitate community integration.
- All facility-based providers and home health agencies must notify an Amerigroup case manager within 24 hours when a member dies, leaves the facility or moves to a new residence or moves outside the service area or state.
- The option to participate in the member's [Interdisciplinary Care Team (ICT)], dependent on the member's need and preference.
- Follow all federal rules and regulations as applicable.

Long Term Services and Supports
Consumer Direction (Consumer Choice Option)

Consumer Choice Option is an Iowa Medicaid program that allows individuals enrolled in mostHome and Community Based Services (HCBS) waivers more flexibility over how their services and supports are provided. Consumer direction affords members the opportunity to have choice and control over how eligible HCBS are provided.

The program gives the member control over their Medicaid waiver dollars so they can develop a plan to meet their needs by directly hiring their own employees and/ or purchasing other goods and services. An Independent Support Broker (ISB) will help the Consumer Choice Option member develop a budget based on the monthly funds approved by their case manager.

Member participation in consumer direction of HCBS is voluntary. Members may elect to participate in or withdraw from consumer direction of HCBS at any time without affecting their enrollment.

To participate in the Consumer Choice Option program, members must live in the state of Iowa, receive Medicaid funding through an HCBS waiver and be referred by their Amerigroup Community-Based Case Manager.

Amerigroup will partner with Veridian Fiscal Solutions to administer the Consumer Choices Option program as the Financial Management Service (FMS) provider for Consumer Choice Option. Veridian will work with members to assist with providing information on their budget and coordination of payment to workers on the member's behalf.

To learn more about the Consumer Choice Option program, visit the Iowa Medicaid web site at www.dhs.iowa.gov/ime/members/medicaid-a-to-z/consumer-choices-option. For more information on Veridian Fiscal Solutions, visit their website at: **https://ccoweb.veridiancu.org/**

Long Term Services and Supports
Electronic Visit Verification

Electronic visit verification (EVV) is a telephone and computer-based system that electronically verifies when service visits occur and documents the precise time service begins and ends. The purpose of EVV is to verify individuals are receiving the services authorized for their support and for which the state or managed care plan is being billed.

Over the next several months the managed care organizations (MCOs) will partner together to identify a single EVV option to be implemented in Iowa. Once identification of the EVV has been completed, the MCOs will work together in conjunction with the state on a rollout and training schedule for providers.

Long Term Services and Supports

Facility Member Liability

Amerigroup recognizes the unique challenges faced by facility providers. Amerigroup works with facilities to address when a member/family that is noncompliant in paying the member liability; including facilitating a transfer if the issue cannot be resolved.

The paragraphs below outline our plan for working with the facility and the member/family to resolve such issues.

1. The facility administrator or office manager contacts the Amerigroup Community-Based Case manager with details regarding the lack of payment of the member liability including:
   - The date the last payment was made.
   - Discussions held with the member/family to date.
   - Correspondence between the member/family to date.
   - History of late and/or missed payments, if applicable.
   - Any knowledge of family dynamics, concerns regarding the responsible party, or other considerations.
2. An Amerigroup Community-Based Case manager and the nursing home social worker, if applicable, discuss the issue with the member, determine the barrier to payment and elicit cooperation:
   - The Amerigroup Community-Based Case manager guides the discussion, including review of the obligation, potential impact to ongoing eligibility, and potential threat to continued residence at the current facility.
   - The Amerigroup Community-Based Case manager screens for any potential misappropriation of funds by family or representative payee.
3. The Amerigroup Community-Based Case manager will discuss the issue with the identified responsible party if the member is unable to engage in a discussion regarding payment of the member liability due to cognitive impairment or other disabilities.
4. The Amerigroup Community-Based Case manager or facility social worker will take action if concerns related to misappropriation of funds are raised or suspected, and may:
   - Refer the member to Adult Protective Services and/or law enforcement.
   - Submit a request to the Social Security Administration to change the representative payee status to the person of the member's choosing or the SNF.
   - Engage additional family members.
   - Engage the Guardianship program to establish a conservator or guardian.
5. The Amerigroup Community-Based Case manager will request copies of the cancelled check or other bank document, and/or request copy of a receipt issued by the facility for payment of liability if the member or responsible party asserts that the required liability has been paid. The Community-Based Case manager will present evidence of payment to the facilitybusiness office and request confirmation that the issue is resolved. The Amerigroup Community-Based Case manager will also engage the assigned Amerigroup LTSS Provider Relations consultant to work with the SNF to improve its processes.
6. Amerigroup will send correspondence that outlines the obligation to pay the member liability, potential impact to ongoing eligibility and potential threat to continued residence at the current facility if the responsible party is unresponsive and/or living out of the area.

- The correspondence will be submitted to the state for review and approval as required.
- The correspondence will provide the responsible party with an opportunity to dispute the allegation and provide evidence of payment.

7. Amerigroup will take the following actions in conjunction with the facility social worker if member liability remains unsatisfied after the first rounds of discussion or correspondence, and:
   - Convene a formal meeting with the facility leadership, member and/or responsible party, Ombudsman, Adult Protective Services representative, other representative of the state as applicable and other parties' key to the discussion.
   - Review the patient liability obligation and potential consequences of continued nonpayment.
   - Attempt to resolve the payment gap with a mutually agreed-upon plan.
   - Explain options if the member or responsible party wishes to pursue transfer to another facility or discharge to the community.

Amerigroup, together with the facility, will engage in any of the following, as may be applicable if the member liability continues to go unsatisfied:

- Update and escalate intervention by Adult Protective Services or law enforcement
- Refer to the state Medicaid Fraud Control Unit or other eligibility of fraud management staff that the state may designate
- Escalate engagement to facilitate a change to representative payee, Power of Attorney, or Guardian
- Escalate appointment of a volunteer guardian or conservator
- Initiate discharge planning

Long Term Services and Supports

Nursing Facility Preadmission Screening and Resident Review

Prior to admission to a nursing facility and any time there is a significant change in status, members will receive a preadmission screening and resident review (PASRR) by the State or its designee. Amerigroup will work with the State or its designee responsible for implementation and oversight of the PASRR process.

The PASRR process must be completed prior to a facility admission. Members entering a nursing facility must have a completed Level I PASRR Screening Tool. If positive, the Amerigroup will ensure the Level II evaluation is completed by the state mental health and/or developmental authority.

If the Level II Evaluation determines the member requires specialized services, the Amerigroup Community-Based Case Manager will ensure the nursing facility complies with federal PASRR requirements to provide, or arrange to provide, specialized services and all applicable Iowa law governing admission, transfer and discharge policies.

A copy of all PASRR documentation (Level I Screening tool and Level II Evaluation, if required) will be maintained in Amerigroup's clinical management system in the member's electronic medical record.

The Amerigroup Community-Based Case Manager will monitor members in accordance with contract visits, and inform members of their right to return to the community. The Amerigroup Community-Based Case Manager will also ensure that members have the option to receive HCBS in more than one residential setting appropriate to their needs and will educate members on the available settings.

Long Term Services and Supports (LTSS)

LTSS Continuity of Care

LTSS Specific Services

Upon enrollment with Amerigroup:

- LTSS services will be authorized until a new comprehensive needs assessment is completed or up to a year in the absence of a completed assessment.
- Members receiving LTSS will be permitted to see all current providers on their approved service plan, including any non-network providers, until an assessment and service plan is completed and either agreed upon by the member or resolved through the appeals or fair hearing process, and implemented.
- LTSS services will not be reduced, modified or terminated in the absence of a new/ up-to-date assessment of needs that would support any service reduction, modification or termination.
- Amerigroup will extend the authorization of LTSS from a non-contracted provider as necessary to ensure continuity of care, pending the provider's contracting with Amerigroup, or the member's transition to a contracted provider.
- Amerigroup shall facilitate a seamless transition to new services and/or providers, as applicable, in the plan of care/service plan developed by Amerigroup without any disruption in services.

Amerigroup shall make every effort to engage the provider in the contracting process so the member may be able to continue with that same provider if the member so desires. The provider would be requested to meet the same qualifications as other providers in the network.

Amerigroup members using a residential provider at the time of enrollment will have continued access to that residential for up to one (1) year, even on a non-network basis. Members cannot be made to move to another residential provider unless the following conditions are met:

- The member or his/her representative specifically requests to transition
- The member or his/her representative provides written consent to the move, based on quality or other concerns raised by Amerigroup.

Any Amerigroup issues regarding the current residential provider's rate of reimbursement or contracted vs. non-contracted status shall not be grounds for moving a member to another residential provider.

If the residential provider is a non-contract provider, Amerigroup may:

- Authorize continuation of the services pending contracting with the provider;
- Authorize continuation of the services for at least thirty (30) days pending facilitation of the member's transition to a contracted provider, subject to the member's agreement with such transition
- Continue to reimburse services from the non-contracted providers

If a member is transitioned to a contracted residential provider, Amerigroup shall extend the authorization of services with the non-contracted provider beyond the minimum thirty (30) day requirement as necessary to ensure continuity of care and the member's seamless transition to a new provider.

Amerigroup will permit a member with a dual diagnosis of a behavioral health condition and developmental disorder to remain with their residential provider for at least one year or with their inpatient psychiatric provider, regardless of network status, as long as the services continue to be medically necessary.

When a provider is not in-network, Amerigroup shall permit members with a dual diagnosis of a developmental disorder and a behavioral health condition to remain with their providers of all outpatient behavioral health services for a minimum of three (3) months, as long as the services continue to be medically necessary. Amerigroup would shorten this transition time frame only if/when that service provider is no longer available to serve the member, or when a change in providers is requested in writing by the member or the member's representative.

Non-LTSS Specific Services

Upon enrollment with Amerigroup:

- Amerigroup will honor existing authorizations for covered benefits for a minimum of (XX) calendar days, without regard to whether such services are being provided by contracted or non-contracted provider, when a member transitions to the Amerigroup Iowa from another source of coverage.
- Existing authorizations will be honored for a minimum of (XX) calendar days when a member transitions to Amerigroup from another source of coverage, without regard to whether services are being provided by contracted or non-contracted providers.
- Amerigroup will utilize processes to identify existing prior authorization of services at the time of the member's enrollment
- Amerigroup shall allow a member who is receiving covered benefits from a non-network provider to continue accessing that provider. Amerigroup shall make commercially reasonable attempts to contract with providers from whom an enrolled member is receiving ongoing care.

CHAPTER 6: Behavioral Health Services

Behavioral Health Services
Overview of Behavioral Health at Amerigroup

The mission of Amerigroup is to coordinate the physical and behavioral health care of members, offering a continuum of targeted interventions, education and enhanced access to care to ensure improved outcomes and quality of life for Amerigroup members. Amerigroup works collaboratively with healthcare providers, including Community Mental Health Centers (CMHCs), Iowa Department of Public Health (IDPH) Substance Use Disorder providers, waiver service providers and a variety of community agencies and resources to successfully meet the needs of members with Mental Health (MH) and Substance Use Disorders (SUDs), including those participating in waiver programs.

Behavioral Health Services
Goals

The goals of the Amerigroup Behavioral Health program are to:

- Ensure adequacy of service availability and accessibility to eligible members.
- Assist members and providers to utilize the most appropriate, least restrictive, medical and behavioral health care in the right place at the right time.
- Promote integration of the management and delivery of physical and behavioral health services to members.
- Achieve Amerigroup's quality initiatives, including those related to HEDIS, NCQA and Iowa Department of Human Services (DHS) performance requirements.
- Work with members, providers and community supports to provide tools and an environment that supports members towards their recovery goals.

Behavioral Health Services
Values

The following values are incorporated into Amerigroup's policies and practices:

- Hope and respect for members and families, based on the knowledge that personally-valued recovery is possible
- A belief in member dignity and self-determination
- The encouragement to strengthen empowering relationships
- The elimination of stigma and discrimination

Behavioral Health Services
Principles

Amerigroup adheres to the following principles related to the delivery of behavioral health services:

- Members are allowed to choose his or her behavioral health professional(s) to the fullest extent possible and appropriate.
- We support the involvement of the member, and those significant in the member's life as appropriate, in decisions about services provided to meet the member's health needs.
- We establish and promote strategies to engage members who may have histories of inconsistent involvement in treatment.

- For adult members who have a serious mental illness and child members with a severe emotional disturbance (SED), services focus on helping the member maintain their home environment, education and employment, and on promoting their recovery and resiliency.
- Mental health services for children are most appropriately directed toward helping a child and the child's family to develop resiliency and maintain a stable and safe family environment for the child.
- A commitment to exploring the use of emerging technology (e.g., telehealth) as a way to expand access to services and extend the reach of mental health and substance use disorder service professionals, particularly into rural areas of the state.
- The coordination of services to eliminate both gaps in service and duplication of services.
- To promote quality improvement initiatives as well as monitoring and tracking outcomes – member satisfaction, health status and clinicial improvement and service utilization.

Behavioral Health Services
Objectives

The objectives of the Amerigroup Behavioral Health program are to:

- Work with care providers to ensure the provision of medically necessary and appropriate care and services to our members at the least restrictive level of care, including inpatient care, alternative care settings, and outpatient care, both in-and out-of-network;
- Provide high quality case management and care coordination services designed to identify member needs and address them in a person-centered, holistic manner;
- Promote continuity and coordination of care among physical and behavioral healthcare practitioners;
- Maintain compliance with local, state, and federal requirements, as well as accreditation standards;
- Utilize evidence-based guidelines and clinical criteria and promote the use of same in the provider community.
- Enhance member satisfaction by working with members-in-need of services to implement an individually-tailored and holistic support and care plan that allows the member to succeed at achieving his/her Recovery and Resiliency goals.
- Enhance provider satisfaction and provider success by working to develop collaborative and supportive provider relationships built on mutually agreed upon goals, outcomes and incentives Promote all health care partners are working together to achieve quality and recovery goals through education, technological supports and the promotion of recovery ideals.
- Initiate quality improvement activites Plan, Do, Study, Act (PDSA)
- Establish systems to monitor and track outcomes

Amerigroup - contracted providers deliver behavioral health and IDPH substance use disorder (SUD) services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by Iowa DHS and IME. This includes, but may not be limited to, mental health services such as psychiatric inpatient hospital services, 24-hour Psychiatric Medical Institutions for Children (PMIC), outpatient mental health services, case management, psychiatric rehabilitation services and behavioral health crisis services. Also included are (SUD) treatment such as inpatient, residential and outpatient services.

Behavioral Health Services
Recovery and Resiliency

"A personal process of overcoming the negative impact of a psychiatric disability despite its continued presence."

— Townsend, W., S. Boyd, G. Griffin, and P. L. Hicks. 2000. Emerging best practices in mental health recovery. Columbus: Ohio Department of Mental Health.

"Recovery involves living as well as possible."

—Slade, M. (2009) Personal Recovery and Mental Illness; A Guide for Mental Health Professionals. New York: Cambridge University Press.

"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

— Substance Abuse and Mental Health Services Administration (SAMHSA, 2011)

Amerigroup believes physical and behavioral health services should be rendered in a manner that supports the recovery of persons experiencing mental illness and enhances the development of resiliency of those who are impacted by mental illness, serious emotional disturbance and/or substance use disorder issues. Recovery is a consumer-driven process in which consumers find their paths to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life despite the continued presence of a disability.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a consensus statement on mental health recovery. The components listed in this consensus statement are reflective of our desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery as elucidated by SAMHSA include:

1. Self-direction: Consumers lead, control and exercise choice over and determine their own path of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
2. Individualized and person-centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliency, as well as his or her needs, preferences, experiences (including past trauma) and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result, as well as an overall paradigm for achieving wellness and optimal mental health.
3. Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions — including the allocation of resources — that will affect their lives and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
4. Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and health care treatment and services, complementary and naturalistic services (e.g., recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person. Families, providers, organizations, systems, communities and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

5. Nonlinear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
6. Strengths-based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
7. Peer support: Mutual support — including the sharing of experiential knowledge and skills and social learning — plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles and community.
8. Respect: Community, systems and societal acceptance and appreciation of consumers — including protecting their rights and eliminating discrimination and stigma — are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
9. Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
10. Hope: Recovery provides the essential and motivating message of a better future — that people can and do overcome the barriers and obstacles that confront them. Hope is internalized but can be fostered by peers, families, friends, providers and others. Hope is the catalyst of the recovery process.

Resiliency is a dynamic developmental process especially for children and youth (and their families) that encompasses positive adaptation and is manifested by traits of self-efficacy, high self-esteem, maintenance of hope and optimism within the context of significant adversity.

Services that are provided to children and youth with serious emotional disturbances and their families are best delivered based on the System of Care Values and Principles that are endorsed by the SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Child-centered and family focused with the needs of the child and family dictating the types and mix of services provided.
- Community-based with the focus of services as well as management and decision-making responsibility resting at the community level.
- Culturally competent with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve.
- Led by the guiding principles of a system of care, which include:
    - Children should have access to a comprehensive array of services that address the child's physical, emotional, social, educational and cultural needs.
    - Children should receive individualized services in accordance with their unique needs and potential, which is guided by an individualized service plan.
    - Children should receive services within the least restrictive, most normative environment that is clinically appropriate.

- Children should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordinating services.
- Children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the child and family.
- Children should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics.

Behavioral Health Services
General Provider Information

How to Become a Behavioral Health Provider on the Amerigroup Iowa, Inc. Network

Please see our credentialing information in this provider manual. If you have questions about the Amerigroup credentialing process before joining our network, call our Network Development team at <1-888-821-1108>. If you are being recredentialed, you will receive a packet of instructions and contact information for questions or concerns.

Amerigroup believes the success of providers is necessary to achieve our goals. We are committed to supporting and working with qualified providers to ensure we jointly meet quality and recovery goals. Such commitment also includes:

- Improving communication of the clinical aspects of behavioral health care to improve outcomes and recovery.
- Supporting providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person.
- Precertification rules, referrals, claims and payment processes to help providers reduce administrative time and focus on the needs of members.
- Using reasonable precertification requirements that minimize administrative burden.

Provider Types and Specialties

Please refer to our Behavioral Health provider type/specialty taxonomy crosswalk at providers.amerigroup.com/ia, under the menu item **Reference & Training**, for reimbursement information by provider type and specialty codes recognized.

Behavioral Health Services
Health Home Services

Overview

Effective January 2012, with CMS approval, Iowa initiated a Health Home program for Medicaid members with chronic medical and behavioral conditions. A state plan amendment on July 1, 2014, extended a statewide health home program for adults and children with mental health conditions, called Integrated Health Homes.

A Health Home supports a member's health care and service needs — physical and mental health and social supports. A Health Home appoints a care coordinator, a health care team and service providers to serve as the member's Health Home in collaboration with Amerigroup. Health Homes are a health service model whereby a member's health service providers and caregivers communicate with one another to address

health needs in a comprehensive manner. This is accomplished with a dedicated care manager who oversees and promotes access among health providers and social service organizations to promote the member's health. Health records are shared among providers (either electronically or on paper) so that services are not duplicated or neglected. The Health Home services are provided through a network of organizations including providers, health plans and community-based organizations. When all of the services are considered collectively, they become a Collaborative Health Home.

A Health Home facilitates access to a range of health and community services, simplifying the process for the member. Core health home services include:

- Comprehensive care management
- Care coordination
- Transitions in care
- Support to individual and family members
- The facilitation of referrals to community services and supports
- Health promotion and self-care

The care coordinator serves as a main point of contact in coordinating between providers and supporting the member. A care coordinator:

- Coordinates care provided by doctors, therapists, counselors, individuals and community supports.
- Talks with providers to assist in setting health goals.
- Learns about member's medications to facilitate adherence and reconcile prescriptions among multiple providers.
- Identifies supports in the community, such as housing and transportation, to address social and community-based barriers to health.

Eligibility Criteria

Chronic Condition Health Home eligibility criteria require members to have one or more of the following:

- Two or more chronic conditions (e.g., mental health condition, substance use disorder, asthma, diabetes, heart disease, a BMI over 25 or other chronic conditions)
- One qualifying chronic condition (e.g., HIV/AIDS) and the risk of developing another
- One serious mental illness

An Integrated Health Home (IHH) is a team of professionals working together to provide person-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). Eligibility for IHH services includes either:

- An adult with an SMI: Psychotic disorders, schizophrenia, schizoaffective disorder, major depression, bipolar disorder, delusional disorder, obsessive compulsive disorder or another mental health diagnosis with significant functional impairment
- A child or youth with an SED: A diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current Diagnostic and Statistical Manual of mental disorders (DSM) that results in a functional impairment.
- Eligibility criteria for either a Chronic Condition Health Home or Integrated Health Home include:
- Members who get full Medicaid benefits
- Members who get full Medicaid benefits and who also have Medicare

Amerigroup will identify eligible members, or an Integrated Health Home Partner may refer a member to Amerigroup for eligibility determination.

Members in the following programs are not eligible for the Health Home program:

- Iowa Health and Wellness Plan
- Qualified Medicare Beneficiary
- Special Low-Income Medicare Beneficiary
- Program of All-Inclusive Care for the Elderly (PACE)
- Iowa Family Planning Network
- Health Maintenance Organization members
- Presumptive Eligible*

**Temporary Medicaid coverage for women who are pregnant, or who need treatment for breast and cervical cancer, and children under the age of 19 who need temporary medical coverage.*

Case management activities for enrollees in the Children's Mental Health Waiver and Habilitation program will be provided through the Integrated Health Home. **Behavioral Health Services**

Services Requiring Precertification

Please visit providers.amerigroup.com/ia to access a full list of covered services, codes and authorization rules.

Please note that Amerigroup does not require notification or prior authorization for emergency medical / behavioral health or substance abuse services.

Members who are admitted to an inpatient hospital / facility under an involuntary detention or commitment (96-hour detentions / court-ordered commitment) will not require prior authorization for those inpatient days while the detention or commitment is in effect.

Behavioral Health Services

Member Records and Treatment Planning

Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews:

- Information related to the provision of appropriate services to a member must be included in his or her record to include documentation in a prominent place, and whether there is an executed declaration for mental health treatment.
- For members in the population, a comprehensive assessment that provides a description of the consumer's physical and mental health status at the time of admission to services. This comprehensive assessment covers:
    - **A psychiatric assessment that includes:**
        - Description of the presenting problem
        - Psychiatric history and history of the member's response to crisis situations
        - Psychiatric symptoms
        - A diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM) and current ICD coding
        - Mental status exam
        - History of alcohol and drug abuse

- **A medical assessment that includes:**
  - Screening for medical problems
  - Medical history
  - Present medications
  - Medication history
- **A substance use assessment that includes:**
  - Frequently used over-the-counter medications,
  - Alcohol and other drugs and history of prior alcohol and drug treatment episodes.
  - History reflecting impact of substance use in the domains of the community functioning assessment.
- **A community functioning assessment or an assessment of the member's functioning in the following domains:**
  - Living arrangements, daily activities (vocational/educational)
  - Social support
  - Financial
  - Leisure/recreational
  - Physical health
  - Emotional/behavioral health
  - An assessment of the member's strengths, current life status, personal goals and needs.

- A patient-centered, wellness –oriented care plan, which is based on the psychiatric, medical, substance use and community functioning assessments listed above, must be completed for any member who receives behavioral health services.
- The patient-centered care plan must be completed within the first 14 days of admission to behavioral health services and updated every 90 days, or more frequently as necessary based on the member's progress towards goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.
- <u>There must be documentation in every case that the member and, as appropriate, his or her family members, caregivers, or legal guardian, participated in the development and subsequent reviews of the treatment plan.</u>
- For providers of multiple services, one comprehensive treatment/care/support plan is acceptable as long as at least one goal is written, and updated as appropriate, for each of the different services that are being provided to the member.
- The treatment/support/care plan must contain the following elements:
  - Identified problem(s) for which the member is seeking treatment
  - Member goals related to problem(s) identified, written in member-friendly language
  - Measurable objectives to address the goals identified
  - Target dates for completion of objectives
  - Responsible parties for each objective
  - Specific measurable action steps to accomplish each objective
  - Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent, de-escalate or defuse crisis situations; names and phone numbers of contacts that can assist the member in resolving crisis; and the member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
  - Signatures of the member as well as family members, caregivers, or legal guardian as appropriate.

- Clinical progress notes are written to document status related to goals and objectives indicated on the treatment plans.
    - Correspondence concerning the member's treatment and signed and dated notations of telephone calls concerning the member's treatment.
    - A brief discharge summary must be completed within 15 calendar days following discharge from services or death.
    - Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the member is receiving behavioral health services.
- Amerigroup will monitor provider compliance with treatment plan requirements through medical record reviews or other measures. Providers who do not meet the goal of 100-percent compliance with treatment plan requirements may be subject to corrective action and may be asked to submit a plan for meeting the 100-percent requirement.

Behavioral Health Services

Adverse Incident Reporting (including Psychiatric Medical Institution for Children, Children's Mental Health Waiver and Habilitation Program Services)

Adverse occurrence (e.g. sentinel events, major critical events) reports must be made by each participating provider to all appropriate agencies as required by licensure and state and federal laws within the specified time frames required immediately following the event. See section on Critical Incident Reporting and Management for more information. Examples of adverse occurrences include, but are not limited to:

- Treatment complications (including medication errors and adverse medication reactions)
- Accidents or injuries to a member
- Morbidity
- Suicide attempts
- Death of a member
- Allegations of physical abuse, sexual abuse, neglect and mistreatment, and/or verbal abuse
- Use of isolation, mechanical restraint or physical holding restraint
- Any clear and serious breach of accepted professional standards of care that could endanger the safety or health of a member or members

Behavioral Health Services

Psychotropic Medication

Iowa law permits the state of Iowa to restrict access to prescription drugs through the use of a Preferred Drug List (PDL) through PA 441 Iowa Administrative Code § 78.2(4)a. Amerigroup will follow and enforce the PDL under the Medicaid Fee-for-Service (FFS) pharmacy benefit for psychotropic medications, which may include prior authorization criteria, quantity limits and days-supply limitations. The PDL is located at www.iowamedicaidpdl.com.

Providers must inform all members being considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication, alternate medications and other forms of treatment. The medical record is expected to reflect such conversations as having occurred.

Members on psychotropic medications may be at increased risk for various disorders. As such it is expected that providers are knowledgeable about side-effects and risks of medications and regularly inquire about and seek for any side-effects from medications. This especially includes:

1. Follow-up to inquire about suicidality or self-harm in children placed on anti-depressant medications as per FDA and APA guidelines.
2. Regular and frequent weight checks and measurement of abdominal girth especially for those on antipsychotics or mood stabilizers.
3. Glucose tolerance test or hemoglobin A-1C tests especially for those members on antipsychotics or mood stabilizers.
4. Triglyceride and cholesterol checks especially for those members on antipsychotics and mood stabilizers.
5. ECG checks for members placed on medications with risk for significant QT-prolongation.
6. Ongoing checks for movement disorders related to antipsychotic use and psychotic disorders.

Guidelines for such testing and follow-up are provided by the American Psychiatric Association, amongst others. Summary guidelines are referenced in Amerigroup's Clinical Practice Guidelines (CPGs) which can be found at providers.amerigroup.com/ia. While the prescriber is not expected to personally conduct all of these tests, the prescriber is expected to ensure that these tests occur where indicated and to initiate appropriate interventions to address any adverse results. These tests and the interventions are expected to be documented in, at minimum, the medical record for the member.

Behavioral Health Services

Utilization Management Process

Utilization Management Decision Making

Individuals involved in utilization management (UM) decisions, is governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Amerigroup does not specifically reward practitioners or other individuals for issuing denial of coverage care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denial of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization, or create barriers to care and service.

Our Behavioral Health Customer Service Staff

Provider calls to our Provider Services line during regular business hours are taken by our experienced team of Utilization Management Representatives (UMRs). UMRs assist providers with routine inquiries about member eligibility, benefits and claims or with referrals to network providers for your patients. If you are calling about precertification for a service that requires precertification and clinical review, these requests are referred to a member of our clinical staff to initiate a review of the request.

Provider calls after business hours are taken by our Amerigroup On Call staff who will issue you a reference number for the precertification request. All requests for precertification will be reviewed by appropriate Behavioral Health staff within decision and notification timeliness standards (see grid below, "Timeliness of Decisions on Requests for precertification").

Behavioral Health Services
Behavioral Health Authorization Time Standards

Amerigroup will make authorization determinations within timeframes that facilitate timely access to care per the standards outlined in Chapter 16. For this to occur, it is critical that Amerigroup receive all necessary clinical information in a timely manner.

Our Clinical Staff

Amerigroup has assembled a highly trained and experienced team of clinical care managers, case managers, and support staff to provide high quality care management and care coordination services to Amerigroup members and to work collaboratively with you, our providers. All clinical staff is licensed and has experience requirements which generally include at least four years of prior clinical experience.

Behavioral Health Services
Notification or Request Preauthorization

The quickest, most efficient way to request precertification is via the provider website at providers.amerigroup.com/ia. If you are a SUD provider, you must utilize the <<INSERT SCREENING TOOL>> screening and assessment tool which is based on American Society of Addiction Medicine (ASAM) criteria. For information on using the<ASSESSMENT TOOL>, please visit providers.amerigroup.com/ia.

You may also provide notification or request preauthorization for mental health services that require preauthorization via phone by calling <<1-800-454-3730>>, 24 hours a day, 7 days a week and 365 days a year. Please be prepared to provide clinical information in support of the request at the time of the call.

You may also request preauthorization via fax. Amerigroup-approved fax forms can be obtained on our provider website at providers.amerigroup.com/ia. The Amerigroup Behavioral Health fax numbers are:

- For inpatient requests: <1-877-434-7578>
- For outpatient requests: <1-866-877-5229>

Note: All requests for precertification for psychological and neuropsychological testing beyond the six-hour initial limit should be submitted via fax at <1-800-505-1193> (see *Provider Forms* section).

Behavioral Health Services
Clinical Criteria

Amerigroup Clinical Criteria

- In addition to utilizing the Iowa Definition of Medical Necessity (see below), Amerigroup utilizes clinical criteria to evaluate the medical necessity of requests for care and services as follows:
    - Mental health: Amerigroup Medical Policies and Clinical Utilization Management Guidelines
    - Substance use disorder: American Society of Addiction Medicine (ASAM) Principles of Addiction Medicine
- Additional level of care criteria will be used for services not included in Amerigroup or ASAM criteria sets. For more information about additional criteria in use by Amerigroup please visit providers.amerigroup.com/ia.
- All criteria used by Amerigroup are approved by the Amerigroup Medical Advisory Committee and the Amerigroup Medical Policy and Technology Assessment Committee.
- For information about how to access to Amerigroup's medical necessity criteria, please call the Amerigroup Provider Services line at <1-800-454-3730>.

Medical Necessity is defined by Iowa as those Covered Services that are determined through Utilization Management to be:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the member;
- Provided for the diagnosis or direct care and treatment of the condition of member enabling the member to make reasonable progress in treatment;
- Within standards of professional practice and given at the appropriate time and in the appropriate setting;
- Not primarily for the convenience of the member, the member's physician or other provider; and
- The most appropriate level of Covered Services, which can safely be provided.

Behavioral Health Services
Behavioral Heath Medical Necessity Determination and Peer Review

When a provider requests initial or continued precertification for a covered behavioral health service, Amerigroup Utilization Managers obtain necessary clinical information and review it to determine if the request appears to meet applicable medical necessity criteria.

If the information submitted does not appear to meet such criteria, the Utilization Manager submits the information for review by an Amerigroup Behavioral Health Medical Director, or other appropriate practitioner, as part of the peer review process.

The Amerigroup reviewer, or the requesting provider, may initiate a peer-to-peer conversation to discuss the relevant clinical information with the clinician working with the member. If an adverse decision is made by the Amerigroup reviewer without a peer-to-peer conversation taking place (as may occur when the provider is unavailable for review), the provider may request such a conversation within two business days of the issuance of the adverse decision. In this case, we will make a Behavioral Health Medical Director, or other appropriate practitioner, available to discuss the case with the requesting provider. This conversation may result in the decision being upheld or changed.

Members, requesting providers and applicable facilities are notified of any adverse decision by Amerigroup within notification timeframes that are based on the type of care requested, and in conformance with regulatory and accreditation requirements.

Behavioral Health Services
Nonmedical Necessity Adverse Decisions

Nonmedical Necessity Adverse Decisions (Administrative Adverse Decision)

A request for precertification may result in an adverse decision for reasons other than a lack of medical necessity. Reasons for such an adverse decision may include:

- The notification of admission was late; providers must notify Amerigroup within 24 hours, or the next business day, of any inpatient admission of an Amerigroup member.
- The provider failed to request precertification of a service that requires it.
- The member was ineligible on the date of service.
- The requested service/benefit was a noncovered service/benefit.

- The limit on the benefit has been reached.

Behavioral Health Services
Provider Appeals, Grievance and Payment Disputes

If precertification was not received or you disagree with the decision, refer to the appeals, grievance and payment disputes section of this manual.

Behavioral Health Services
Avoiding and Adverse Decision

Most administrative adverse decisions result from nonadherence to or a misunderstanding of utilization management policies. Familiarizing yourself and your staff with notification and precertification policies and acting to meet those policies can eliminate the majority of these decisions. Other administrative adverse decisions result from misinformation about the member's status or the member's benefits. Such information is readily available from Amerigroup by calling Provider Services at <<1-800-454-3750>>.

Adverse decisions of a medical nature are rare. Such adverse decisions usually involve a failure of the clinical information to meet evidenced-based, national guidelines. Amerigroup is committed to working with all providers to ensure that such guidelines are understood and to identify gaps for providers around meeting such guidelines. Peer-to-peer conversations (between an Amerigroup medical director and the provider clinicians) are one way that Amerigroup is able to ensure the completeness and accuracy of the clinical information and provide a one-on-one communication about the guidelines as necessary. Medical record reviews are another way to ensure that clinical information is complete and accurate. Providers that are able to appropriately respond in a timely fashion to peer-to-peer and medical record requests are less likely to encounter dissatisfaction with the utilization management process. Amerigroup is committed to ensuring a process that is quick and easy and will work with participating providers to ensure a mutually satisfying process where possible.

Reducing Risk to Members With Behavioral Health or SUD Health Care Needs Through the Amerigroup Case Management/Care Coordination Process

- When a member is identified as having mental health and/or SUD needs requiring some type of intervention to reduce risk, Amerigroup utilizes the following strategies:
  - Inpatient management: mmoderate to high-risk hospitalized members
    - When "at risk" members are identified as part of the census management process, the UM staff works with provider discharge planners, our Transitional Care Coaches, the member's health home team and/or Amerigroup Case Managers to develop a discharge plan that maximizes the likelihood of the member making a successful transition back into the community. Key elements of the discharge plan include, but are not limited to:
      - Understanding the characteristics of each particular member (job, family, education, social activities, family background, prior service utilization, etc.)
      - In the case of rapid readmissions – an admission that occurs within 30 days of discharge from the same level of care:
        - What has worked in the past in helping this member to stay out of the hospital (e.g., medications, treatment interventions, services, and supports)?
        - What elements of the previous discharge plan did not work and need to be changed?

- How do medical issues or complications impact the member?
- What is the involvement of the family in the treatment process and how do the family and other social supports factor into the discharge plan?
- Are follow-up appointments scheduled prior to discharge?
- The Behavioral Health Medical Director conducts daily UM rounds and participates in complex case rounds to assist in facilitating the member's successful transition back into the community

– Transitional care: moderate to high-risk hospitalized members
  - A Health Home Care Coordinator collaborates with the UM staff to work with members, their family caregivers, their health home team and, when appropriate, the hospital's discharge planning staff to develop a discharge plan. The plan may include:
    - Pretransition contacts
    - Assisting the member with planning for follow-up care and ensuring that appointments are scheduled, transportation arranged, etc.
    - Post-discharge contacts
    - Medication reconciliation
    - "Red-flag" education for the member and family/caregiver, as appropriate, about potential problems or relapse triggers
    - Disease-specific interventions
  - Transitional Care is a short-term intervention strategy with the goals of reducing the member's risk of readmission and increasing the likelihood that he or she will make a successful transition back into the community.
– Complex case management
  - Once a member is identified as having complex case management needs through identification methods outlined above, the Case Manager attempts to engage the member to conduct an assessment to determine the member's care management needs.
  - The Case Manager works with the member, as well as the member's family/caregiver, as appropriate, to identify goals that are expressed in member-friendly language.
  - The care plan includes interventions that are agreed upon to achieve the member's goals.
  - The Case Manager also obtains input from the member's PCP and other specialty providers in developing the care plan.
  - For members with mental health and/or SUD needs, the Case Managers ensures that all needed behavioral health and medical care needs are integrated in a holistic manner, by facilitating communication among treating providers and scheduling regular case conferences as required. The Case Manager may also utilize complex case rounds to obtain input on especially difficult integration issues.
  - The Case Manager then monitors the member's progress, at regular intervals depending on the member's acuity, in meeting care plan goals. The Case Manager coordinates care and services with all treating providers, and assists the member with community resource referrals. Contacts with the member may be done telephonically, or through face-to-face contact, depending on the member's level of acuity.
  - Case Management continues until the care plan goals have been substantially met or there is agreement with the member/family/caregiver, as appropriate, that further care management is not indicated.
– Amerigroup Disease Management Centralized Care Unit (DMCCU)
  - The needs of lower acuity members with mental health or substance use disorder needs may be met through the DMCCU through some combination of:

- Lower acuity telephonic care management
- Disease Management programs (schizophrenia, major depression, bipolar disorder or substance use disorder)
- Referrals to preventive services
- Providing them with health promotion materials.

Behavioral Health Services
Behavioral Health Drug Utilization Review Program

Our Psychotropic Drug Utilization Review Program processes medical and pharmacy claims data to identify and outreach to prescribers who are not following recommended evidence-based psychotropic treatment guidelines. Our goal is not to infringe on the prescriber's decision-making practice; but rather, to provide education and training on best practices for prescribing psychotropic medications to support prescriber self-regulation. We design educational information to help the prescriber make care decisions based on the latest medical evidence. We monitor claims data to determine whether the Provider makes changes after intervention. DUR programs have been shown to be effective at improving healthcare quality while reducing medical and/or pharmacy costs.

Behavioral Health Services
Post-Discharge Outreach, Diversion Plans and Crisis Assessments

Post-Discharge Outreach

Amerigroup inpatient providers are required to conduct outreach to all members being discharged from inpatient care to encourage the member's attendance at follow-up appointments to be scheduled with a behavioral health specialty provider within seven calendar days of discharge.

Amerigroup will require providers to maintain records of the results of such outreach efforts and will require reporting of this information to Amerigroup on a regular basis. Amerigroup will also conduct on-site audits of member records on at least a quarterly basis.

Providers are also encouraged to use these outreach opportunities to ensure that discharged members/ caregivers have been able to fill necessary prescriptions and have access to transportation for follow-up appointments. If members/caregivers need assistance with filling prescriptions, with transportation to their appointments, or with appointment scheduling, they should be encouraged to contact Amerigroup Member Services at <<1-800-600-4441>>(TTY 711) for assistance.

Diversion Plans

When clinically indicated, Amerigroup encourages providers conducting crisis assessments for members at risk for admission to higher levels of care (e.g., acute inpatient, PMIC) to carefully consider the opportunity for developing diversion plans, with appropriate member and family/caregiver involvement, to assist the member in safely achieving stabilization at a lower level of care.

The provider should contact the member/family/caregiver, as appropriate, as soon as possible following the diversion to offer needed outpatient services.

Crisis Assessments

Providers delivering crisis assessments/screenings to members must initiate a follow-up contact within one business day to any member seen for or provided with any emergency service and not detained for inpatient care and treatment, to determine the need for any further services or referral to any services.

Behavioral Health Services

Clinical Practice Guidelines

All providers have ready access to evidence-based clinical practice guidelines for a variety of behavioral health disorders commonly seen in primary care, including ADHD, bipolar disorder for adults and adolescents, major depressive disorder, schizophrenia, and SUDs as well as evidence-based information on the use of psychotropic medications. Please see the provider website at **providers.amerigroup.com/ia**.

Coordination of Behavioral Health and Physical Health Treatment

- Amerigroup puts special emphasis on the coordination and integration of physical and behavioral health services, wherever possible. Key elements of the Amerigroup model of coordinated care include:
  - Ongoing communication and coordination between PCPs and specialty providers, including behavioral health (mental health and substance use) providers
  - The expectation that providers screen for co-occurring disorders, including:
    - Behavioral health screening by PCPs
    - Medical screening by behavioral health providers
    - Screening of mental health patients for co-occurring SUDs
    - Screening of consumers in substance use disorder treatment for co-occurring mental health and/or medical disorders
  - Screening tools for PCPs and behavioral health providers can be located at **providers.amerigroup.com/ia**
  - Referrals to PCPs or specialty providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders
  - Involving members, as well as caregivers and family members, as appropriate, in the development of patient-centered treatment plans. Case management and disease management programs to support the coordination and integration of care between providers
- As an Amerigroup network provider, you are required to notify a member's PCP when a member first enters behavioral health care and anytime there is a significant change in care, treatment or need for medical services, provided that you have secured the necessary release of information. The minimum elements to be included in such correspondence are:
  - Patient demographics
  - Date of initial or most recent behavioral health evaluation
  - Recommendation to see PCP, if medical condition identified or need for evaluation by a medical practitioner has been determined for the member (e.g., EPSDT screen, complaint of physical ailments)
  - Diagnosis and/or presenting behavioral health problem(s)
  - Prescribed medication(s)
  - Vital Signs
  - Allergy/Drug Sensitivity
  - Pregnancy Status
  - Behavioral health clinician's name and contact information (See Forms Section)

Behavioral Health Services
Provider Training

Amerigroup must monitor and ensure all participating providers that deliver Behavioral Health services provide relevant staff with training in accordance with Iowa DHS requirements. As a contracted provider of Amerigroup, your organization is required to provide training to your staff as appropriate. Your organization is also responsible for complying with any updates in training requirements. Additionally, Amerigroup will implement measures to monitor compliance with training requirements.

Additional Training

Amerigroup will present training programs for PCPs and behavioral health providers on topics related to the coordination of behavioral health and physical health care. Some of these training events will include the opportunity for providers to obtain CME/CEU credit for participation. Please consult the Amerigroup provider website at providers.amerigroup.com/ia for a schedule of these training events.

Behavioral Health Consultations for Primary Care Providers

Amerigroup will provide all contracted PCPs with the ability to consult with a behavioral health specialist. For more information about this and other behavioral health consultation resources please call the Amerigroup Provider Services line at <<1-800-454-3730>>.

Behavioral Health Services
Behavioral Health Waivers

1915(c Children's Mental Health (CMH) Services Waiver

Amerigroup delivers the state's 1915(c) CMH Waiver services to all members meeting the eligibility criteria and authorized to be served by these programs. Children enrolled in the CMH Waiver program will also be enrolled in an Integrated Health Home. Amerigroup is responsible for: (i) assessment of needs-based eligibility; (ii) service plan review and authorization; (iii) claims payment; (iv) provider recruitment; (v) provider agreement execution; (vi) rate setting; and (vii) providing training and technical assistance to providers.

CHAPTER 7: MEMBER ELIGIBILITY

Provider Services: **<<1-800-454-3730>>**
Provider Services Fax: **<1-800-964-3627>**
Hours of Operation: **Monday to Friday, 7:30 a.m.-6 p.m.** Central time
Website: **providers.amerigroup.com**
Hours of Operation: **24 hours a day, 7 days a week**

Website: **http://dhs.iowa.gov/Member Eligibility**

Overview

Given the increasing complexities of health care administration, widespread potential for fraud and abuse and constant fluctuations in program membership, providers need to be vigilant about member eligibility. This may mean taking extra steps to verify that any patient treated by network providers is, in fact, a currently enrolled Amerigroup Iowa, Inc. member.

Amerigroup members enrolled in IA Health Link are required to carry and present their IA Health Link identification (ID) card when seeking services. The IA Health Link ID card is issued by the state of Iowa. To prevent fraud and abuse, providers should confirm the identity of the person presenting the ID card. Providers also must verify a member's eligibility before services are delivered. Because eligibility can change, verify eligibility at each visit. Remember: Claims submitted for services rendered to noneligible members are not eligible for payment.

Member Eligibility

How to Verify Member Eligibility

Providers can verify member eligibility as follows:

- Availability is 24 hours a day, 7 days a week for real-time member enrollment and eligibility verification for all IA Health Link programs. Or, use the website to determine the member's specific benefit plan and coverage:
  - Automated voice response: <1-800-947-3544> (24 hours a day, 7 days a week)
  - IA Health Link website: <website>
- Contact Provider Services to verify enrollment and benefits for our members:
  - Phone: <<1-800-454-3730>> (Monday to Friday, 7:30 a.m.-6 p.m.) Central time
  - Amerigroup's secure Provider portal on the **Providers** page of our website: **providers.amerigroup.com**/ia**.** Click on **Login** or **Register** to access the secure site.
  - Please refer to the Primary Medical Group Member Assignment Lock-in Program section above regarding additional requirements for verification of member eligibility.
- Paper panels are available if specifically requested.

Member Eligibility

IA Health Link ID Cards

The IA Health Link Member ID card includes the following information:

- Member name
- Member ID number (10 digits, no prefix)

Members will receive an Amerigroup ID number and ID card. The front includes both the Amerigroup ID, the IAHealth Link ID assigned by the state, and the name and phone number of the primary medical group (PMG) where the member is assigned. The back includes the mailing address for paper claims, important phone numbers, and the general correspondence and appeal mailing address.

CHAPTER 8: MEDICAL MANAGEMENT

Medical Management Phone: **<<1-800-454-3730>>**
Medical Management Fax: **<<1-800-964-3627>>**
Hours of Operation: **Monday to Friday, 8 a.m.-5 p.m. Central time**

Medical Management

Overview

Amerigroup's Medical Management program is a cooperative effort with providers to promote, provide and document the appropriate use of health care resources. Our goal is to provide the right care, to the right Member, at the right time, in the appropriate setting.

The decision-making process is based on guidelines from the National Committee for Quality Assurance (NCQA) and reflects the most up-to-date medical management standards. Health care authorizations are based on the following:

- Benefit coverage
- Established criteria
- Community standards of care

The decision-making criteria used by the Medical Management department are evidence-based and consensus-driven. We update criteria periodically as standards of practice and technology change. We involve practicing physicians in these updates and then notify providers of changes through fax communications (such as provider bulletins), and other mailings. Based on sound clinical evidence, the Medical Management department provides the following service reviews:

- Precertification
- Concurrent/continued stay reviews
- Post-service reviews

Decisions affecting coverage or payment for services are made in a fair, consistent and timely manner. The decision-making process incorporates nationally-recognized standards of care and practice from sources, including:

- American College of Cardiology
- American College of Obstetricians and Gynecologists
- American Academy of Pediatrics
- American Academy of Orthopedic Surgeons
- Cumulative professional expertise and experience

After a case has been reviewed, decisions and notification time frames will be given for service:

- Approval
- Modification
- Denial

Please note: UM decision-making is based only on appropriateness of care and service and existence of coverage. Amerigroup does not specifically reward practitioners or other individuals for issuing denial of coverage care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denial of benefits. There are no financial incentives for UM decision-makers that encourage decisions resulting in under-utilization, or create barriers to care and service.

If you disagree with a decision and want to discuss the decision with the Physician Reviewer, call the Medical Management department at <<1-800-454-3730>>.

Medical Necessity is defined by Iowa as those Covered Services that are determined through Utilization Management to be:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the member;
- Provided for the diagnosis or direct care and treatment of the condition of member enabling the member to make reasonable progress in treatment;
- Within standards of professional practice and given at the appropriate time and in the appropriate setting;
- Not primarily for the convenience of the member, the member's physician or other provider; and
- The most appropriate level of Covered Services, which can safely be provided.

Medical Management

Services Requiring Precertification

Some common services requiring precertification include:

- Air ambulance
- Behavioral health (all inpatient and outpatient services require precertification. For specialist referrals and precertification call: <<1-800-454-3730>>)
- Biofeedback
- Circumcision (Amerigroup covers routine circumcision without precertification for up to 12 months of age. After 12 months of age, medical necessity review is required)
- Durable medical equipment and disposable supplies
- Genetic testing (except routine amniocentesis and prenatal testing)
- HealthCheck (preventive health check-ups for members under the age of 21)
- Home health care services
- Hyperbaric oxygen therapy (no coverage for use of equipment)
- Infusion/injection therapy
- Inpatient hospital services
- Inpatient surgeries and procedures
- Outpatient surgeries and procedures
- Pharmacy
- Physician services (referrals to out-of-network specialists require precertification)
- Radiology services
- Spinal surgeries (lumbar fusion, disc excision and decompression surgery)
- Therapy services (physical, occupational and speech therapies)
- Transplant services
- Vision (Most routine vision services do not require precertification. If you have questions, call Superior Vision at <<1-866-819-4298>>.)

To determine prior authorization requirements use the lookup tool on the precertification page of our website at <<**providers.amerigroup.com/ia**>>. For directions on how to access the providers page of our website, see **Chapter 1: How to Access Information, Forms and Tools on Our Website**.

Please note: Emergency hospital admissions do not require **precertification**. However, notification is required within 24 hours or the next business day.

Medical Management
Services Not Requiring Precertification

The following services do not require precertification when the provider is within the Amerigroup network:

- Dialysis
- Emergency services (notify Amerigroup of hospital admissions within 24 hours or the next business day)
- Family planning or well woman check-up. Member may self-refer to any IA Health Link provider for the following services:
  - Birth control
  - Federal Drug Administration (FDA)-approved family planning devices and supplies (for example, intra-uterine devices)
  - Genetic counseling
  - Screening for human immunodeficiency Virus (HIV) or Sexually Transmitted Infections (STIs)
  - Lab work
  - Pelvic and breast examinations
- Laboratory services (in-network laboratories)
- Obstetrical care -please notify us of the following:
  - Pregnancies: use the **Maternity Notification** form located at providers.amerigroup.com/ia. Select **Medical**>**Forms** and then **Maternity Notification** form.
    - Members may self-refer to a network OB/GYN.
    - Note: We only require notification; precertification is not required for labor and delivery or OB services, including OB visits, diagnostic tests, laboratory services, prenatal/postpartum office visits or ultrasounds when performed by a participating provider.
  - The first prenatal visit: within three days
  - Within 24 hours of delivery: Please include newborn information using the **Newborn Notification of Delivery Form** (baby's date of birth, mode of delivery, gender, weight in grams, gestational age in weeks and disposition at birth).
  - The mother's pediatrician selection for continuity of care.
- Transportation services <<1-866-907-1493>>
- Physician referrals (in-network for consultations or a nonsurgical course of treatment)
- Standard X-rays or ultrasound

Medical Management
Starting the Process

Contact us with questions or precertification requests regarding health care services, including:

- Routine, nonurgent care reviews
- Urgent or expedited preservice reviews
- Urgent concurrent or continued stay reviews

You may request precertification for medical or behavioral health concerns or report a medical admission. To reach the Medical Management department, contact us as follows:

Phone: <<1-800-454-3730>>
Fax: <1-800-964-3627>

The Medical Management department will return calls:

- Same day when received during normal business hours
- Next business day when received after normal business hours
- Within 24 hours for all routine requests

Providers may fax the Medical Management department and include requests for:

- Urgent or expedited preservice reviews
- Non-urgent concurrent or continued stay reviews

Faxes are accepted during and after normal business hours. Faxes received after hours will be processed the next business day.

Medical Management

Requesting Precertification

To request precertification or report a medical admission, call the Medical Management department and have the following information ready:

- Member name and IAHealth Link identification (ID) number
- Diagnosis with the International Classification of Diseases (ICD) code
- Procedure with the Current Procedural Terminology (CPT) code
- Date of injury or hospital admission and third-party liability information, if applicable
- Facility name, if applicable
- Primary care physician (PCP)
- Specialist or attending Physician name
- Clinical justification for the request
- Level of care
- Lab, radiology and pathology test results
- Medications
- Treatment plan, including time frames
- Prognosis
- Psycho-social status
- Exceptional or special needs issues
- Ability to perform activities of daily living
- Discharge plans

All providers, including physicians, Hospitals and ancillary providers are required to provide information to the Medical Management department. Obtain a separate precertification for each service requiring approval. Precertification is necessary whether an in-network or out-of-network provider performs the service. For the latest information about which services require precertification, access the **Providers** page of our website: **providers.amerigroup.com/ia** and select the **Precertification** tab on the left.

Medical Management

Chronic Condition Health Home and Integrated Health Home

Chronic Condition Health Home eligibility criteria require members to have one or more of the following:

- Two or more chronic conditions (e.g., mental health condition, substance use disorder, asthma, diabetes, heart disease, a BMI over 25 or other chronic conditions)
- One qualifying chronic condition (e.g., HIV/AIDS) and the risk of developing another
- One serious mental illness

Note: The PCP determines eligibility.

An Integrated Health Home (IHH) is a team of professionals working together to provide person-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). Eligibility for IHH services includes either:

- An adult with an SMI: Psychotic disorders, schizophrenia, schizoaffective disorder, major depression, bipolar disorder, delusional disorder, obsessive compulsive disorder or another mental health diagnosis with significant functional impairment
- A child or youth with an SED: A diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current Diagnostic and Statistical Manual of mental disorders (DSM) that results in a functional impairment.

Eligibility criteria for either a Chronic Condition Health Home or Integrated Health Home include:

- Members who get full Medicaid benefits
- Members who get full Medicaid benefits and also have Medicare

Health Home Community-Based Providers (Health Home Partners)

Health home community-based providers are selected based on meeting provider standards as described in Iowa State Plan Amendment to CMS approved June 08, 2012 for chronic health conditions and Integrated Health Home for adults and children approved June 18, 2013.

a) Chronic Condition health home providers will be registered with the State and include staff to fill the following roles
   i) Designated Practitioner
   ii) Dedicated Care Coordinator
   iii) Health Coach
   iv) Clinical Support Staff
b) Integrated Health Home partners will meet Iowa certification and accreditation standards, be able to provide community-based mental health services, and in conjunction with Amerigroup Iowa, include a Physician and a Psychiatrist, who hold an active Iowa license, that may be employed by Amerigroup Iowa or the health home partner. The health home partner will have:
   i) Nurse Care Manager
   ii) A Social Work Care Coordinator
   iii) Peer Support Specialist or Family Support Specialist

Amerigroup Iowa, Inc. will provide supports, consultation and training for health home partners.

a) A statewide network of Chronic Condition and Integrated Health Home partners

b) Oversight and technical support to deliver integrated physical and behavioral health services and supports
c) Provide infrastructure and support to health home partners including access to Member 360
d) Coordinate care between Amerigroup care managers and medical staff
e) Track, monitor and report on medical services to reduce gaps in care
f) Provide clinical guidelines and decision support tools, and screening and assessment instruments
g) Support health home partners on the implementation and utilization of health information technology including electronic health records and continuity of care document exchange
h) Facilitate shared treatment planning meetings for members with complex situations
i) Ensure that Integrated Health Home (IHH) care coordinators serving 1915(i) Habilitation and 1915© CMH Waiver members adhere to assessment, service planning, documentation, and monitoring requirements
j) Establish a continuous quality improvement program that includes ability to evaluate outcomes on a program basis as well as an individual-level basis
    i) Clinical outcomes
    ii) Self-management
    iii) Experience of care, member satisfaction
    iv) Service utilization

Payment and Incentive Payments

Health Home partners will be paid a monthly payment (Per Enrollee Per Month) based on tiered approach with an eligible bonus for meeting quality standards to be defined in the provider contract.

Medical Management
Requests with Insufficient Clinical Information

When the Medical Management department receives requests with insufficient clinical information, we will contact the provider with a request for the information reasonably necessary to determine medical necessity. We will make at least one attempt to contact the requesting provider to obtain this additional information. If we do not receive a response, the request will be reviewed with the information originally submitted and denied. A denial letter will be sent to both the member and the provider.

Medical Management
Urgent Requests

Urgent requests are handled by the Medical Management Department. The Medical Management department completes a pre-service review within 72 hours from receipt of the clinical information. Generally speaking, the provider is responsible for contacting us to request preservice review for both professional and institutional services. However, the hospital or ancillary provider also should contact Amerigroup to verify preservice review status for all non-urgent care before rendering services.

Medical Management
Emergency Medical Services

Amerigroup does not require precertification for treatment of emergency medical conditions. In the event of an emergency, members may access emergency services 24 hours a day, 7 days a week. If the emergency room visit results in the member's admission to the hospital, providers must contact Amerigroup within 24 hours or the next business day.

Medical Management
Emergency Stabilization and Post-Stabilization

The emergency department's treating provider determines the services needed to stabilize the member's emergency medical condition. After the member is stabilized, the emergency department's provider must contact the Amerigroup for authorization of further services. If we do not respond within one hour, the necessary services would be considered authorized.

The emergency department should send a copy of the emergency room record to the PCP's office within 24 hours. The PCP should:

- Review and file the chart in the member's permanent medical record
- Contact the member
- Schedule a follow-up office visit or a specialist referral, if appropriate

Medical Management
Concurrent Review: Hospital Admissions

Hospitals must notify us of admission within 24 hours of admission or by the next business day. Notify us about the following admissions:

- Behavioral health
- Medical care
    - Inpatient admissions
    - Observation admissions (notification only required)
- Substance abuse

After notification of an inpatient admission is received, we will send a request for clinical information supporting the admission's medical necessity. Evidence-based criteria are used to determine medical necessity and the appropriate level of care.

Medical Management
Concurrent Review: Clinical Information for Continued-Stay Review

When a member's hospital stay is expected to exceed the number of days authorized during preservice review, or when the inpatient stay did not have preservice review, the hospital must contact us for continued stay review. We require clinical reviews on all members admitted as inpatients to:

- Acute care hospitals
- Intermediate facilities
- Skilled nursing facilities

We perform these reviews to assess medical necessity and determine whether the facility and level of care are appropriate. Amerigroup identifies members admitted as inpatients by:

- Facilities reporting admissions
- Providers reporting admissions
- Members or their representatives reporting admissions
- Claims submitted for services rendered without authorization
- Preservice authorization requests for inpatient care

The Medical Management department will complete a continued-stay inpatient review within 24 hours of receipt of clinical information or sooner, consistent with the member's medical condition. Medical Management Nurses will request clinical information from the hospital on the same day as notification regarding the member's admission and/or continued stay. Providers should notify the health plan of an inpatient admission within 24 hours of the admission.

If the information meets medical necessity review criteria, we will approve the request within 24 hours of receipt of the information. We will send requests that do not meet medical policy guidelines to the Physician Adviser or Medical Director for further review. In addition to notifying providers of the decision within 24 hours, we will send written notification of denial or modification of the request to the member and the requesting provider.

Medical Management
Concurrent Review: Second Opinions

The following are important guidelines regarding obtaining a second opinion:

- The second opinion must be given by an appropriately-qualified health care professional.
- The second opinion must come from a provider of the same specialty as the first provider.
- The secondary specialist may be selected by the member.
- The secondary specialist must be within Amerigroup's network. When there is no network provider who meets the qualification, we may authorize a second opinion by a qualified provider outside of the network, upon request by the member or provider.

A second opinion regarding medical necessity is a covered service, offered at no cost to our members.

Medical Management
Denial of Service

Only a medical or behavioral health provider with an active professional license or certification may deny services for lack of medical necessity, including the denial of:

- Procedures
- Hospitalization
- Equipment

When a request is determined to be not medically necessary, the requesting provider will be notified of the following:

- The decision
- The process for appeal
- How to reach the reviewing physician for peer-to-peer discussion of the case

- How to request the criteria and guidelines on which the decision was based

To contact the physician clinical reviewers to discuss a decision, providers may call the Medical Management department at <<1-800-454-3730>>.

Medical Management
Referrals to Specialists

The Medical Management department is available to assist providers in identifying a network specialist and/or arranging for specialist care. Please keep in mind that specialists must be Iowa Medicaid-certified, whether in-network or out-of-network. Also keep in mind the following Medical Management guidelines. Authorization is:

- Required when referring a member to an out-of-network specialist.
- Required for an out-of-network referral when an in-network specialist is not available in the geographical area.
- Not required if referring a member to an in-network specialist for consultation or a nonsurgical course of treatment.

Provider responsibilities include documenting referrals in the member's chart and requesting the specialist to provide updates about diagnosis and treatment.

Please note: Obtain a precertification approval number before referring members to an out-of-network provider. For out-of-network providers, we require precertification for the initial consultation and each subsequent service.

Medical Management
Additional Services: Behavioral Health

Amerigroup is committed to providing a continuum of care management from initial contact to coordination of care and interventions. Our Behavioral Health Care Managers work closely with our medical Case Managers to support the behavioral health services needed by our members. The key to this support system is Amerigroup's 3-tiered system:

- **Tier 1**: Member Services and outreach calls to members.
- **Tier 2**: Increased interaction with members to assist with provider referrals, problem-solving and removing obstacles to receiving treatment.
- **Tier 3**: Intensive case management offering interventions on an episodic basis or triggered by a long length of stay, medical and behavioral health comorbidity, and/or multiple admissions.

Contact the Medical Management department for more information and precertification of all behavioral health, facility-based care, including:

- Inpatient admissions
- Intensive outpatient program
- Emergency department visits
- Partial hospitalization programs
- Pharmacological management

Please have the following information ready when requesting a referral:

- Clinical information supporting the request

- Diagnosis with ICD code
- First date of outpatient service or date of hospital admission
- Procedure with CPT and/or HCPCS codes
- Specialist or attending provider name

Medical Management

Additional Services: Vision Care

Members have access to basic vision care services through Superior Vision Care providers. For confirmation of vision services, contact Superior Vision Care at <<1-866-819-4298>>.

CHAPTER 9: HEALTH SERVICES PROGRAMS

Provider Services: **<<1-800-454-3730>>**
Provider Services Fax: **<1-800-964-3627>**
Hours of Operation: **Monday to Friday, 7:30 a.m.-6 p.m. Central time**

Health Services Programs
Overview

At Amerigroup, we are proud of our joint efforts with the community-based health organizations to maximize health care services for our members. These service organizations include:

- **Diabetes Prevention program**
- **Iowa Department of Human Services**
- **Local health departments**
- **Prenatal care coordination agencies**
- **School-based service providers**

Our approach is collaborative, results-oriented, community-based and member-centered.

We encourage providers to work with these community organizations to coordinate care, ensure continuity and provide culturally appropriate services to our members enrolled in IA Health Link. Our agreements offer clear guidelines for sharing clinical data that can help our members lead healthier lives.

The intent of our collaboration with our community partners is to supplement providers' treatment plans. When combined with our own Health Services programs, they can improve our members' overall health by informing, educating and encouraging self-care. The targeted programs are divided into four categories:

- Preventive Care programs, including Taking Care of Baby and Me® for mothers-to-be, Well Woman for keeping women healthy at any stage of life, and HealthCheck, a health screening and immunization program for members under the age of 21.
- Health management programs, that promote knowledge and encourage self-care for specific medical conditions and chronic disease, including diabetes, asthma and heart disease.
- Health Education, including our Amerigroup On Call, a phone line available 24 hours a day, 7 days a week for all health-related questions.
- Telehealth, a unique health care delivery method utilizing computers and videoconferencing equipment to connect providers to specialists in different locations.

Health Services Programs
Preventive Care: Initial Health Assessments

The Initial Health Assessment (IHA) offers a baseline for providers to assess and manage a member's physical condition. Providers then offer the educational support necessary to allow members to become more actively engaged in their own treatment and preventive health care.

We encourage our members to schedule a visit with their new PCP as soon as possible after enrollment. The IHA should include the following categories of patient information:

- Patient history
- Physical examination
- Developmental assessment

Health Services Programs
Preventive Care: Well Woman

The Well Woman program was designed to remind and encourage women to have regular cervical and breast cancer screenings. PCP responsibilities for the care of female members include:

- Educating members on preventive health care guidelines for women
- Informing and referring members for cervical and breast cancer screenings
- Scheduling screening exams for members

If the PCP is not a women's health specialist, Amerigroup will offer female members direct access to women's health specialists within the network for covered, routine and preventive health care services.

Members have the right to receive family planning services, in addition to routine care, from any Medicaid provider. In addition, members have the right to receive tuberculosis, sexually transmitted infection (STI) and human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) care from any public health agency.

Health Services Programs
Preventive Care: Taking Care of Baby and Me®

Taking Care of Baby and Me® is a proactive case-management program for all expectant mothers and their newborns. It identifies pregnant women as early in their pregnancies as possible through review of state enrollment files, claims data, lab reports, hospital census reports, and provider notification of pregnancy and delivery notification forms and self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. Case managers collaborate with community agencies to ensure mothers have access to necessary services, including transportation, WIC, home-visitor programs, breastfeeding support and counseling.

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That’s why we encourage all of our moms-to-be to take part in our Taking Care of Baby and Me® program — a comprehensive case management and care coordination program offering:

- Individualized, one-on-one case management support for women at the highest risk
- Care coordination for moms who may need a little extra support
- Educational materials and information on community resources
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born

As part of the Taking Care of Baby and Me® program, members are offered the My Advocate™ program. This program provides pregnant women proactive, culturally appropriate outreach and education through Interactive Voice Response (IVR), text or smart phone application. This program does not replace the high- touch case management approach for high-risk pregnant women. However, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers and improve member and baby outcomes. Eligible members receive regular calls with tailored content from a voice personality (Mary Beth). For more information on My Advocate visit www.myadovcatehelps.com.

For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the You and Your Baby in the NICU program. Parents receive education and support to be involved in the care of their babies, visit

the NICU, interact with hospital care providers and prepare for discharge. Parents are provided with an educational resource outlining successful strategies they may deploy to collaborate with the care team.

Our case managers are here to help you. If you have a member in your care that would benefit from case management, please call us at <<1-800-454-3730>>. Members can also call our Amerigroup On Call at <1-800-224-0336>, available 24 hours a day, 7 days a week.

Health Services Programs

Preventive Care: Long-acting Reversible Contraception

IA Health Link members have access to immediate postpartum placement of long-acting reversible contraception (intrauterine devices [IUDs] and etonogestrel implants) during their inpatient delivery admission. Physicians may implant the device of the patient's choice. Facilities and providers will receive the same reimbursement as if the device were implanted on an outpatient basis.

To help ensure the devices are immediately available to patients, postpartum facilities are encouraged to stock obstetrical units with the LARC devises. The device HCPCS codes and insertion CPT codes for the inpatient procedure are noted below:

HCPCS code	Description
J7300	Intrauterine copper contraceptive
J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies
CPT code	**Description**
11981	Insertion, non-biodegradable drug delivery implant
58300	Insertion of IUD

Unintended pregnancies continue to be a major health problem in the United States. These unintended pregnancies are associated with higher rates of maternal and neonatal complications of pregnancy. Long-acting methods are more effective at preventing unintended pregnancies, have significantly greater continuation rates than oral contraceptives, the vaginal contraceptive ring or the contraceptive patch, and have very low rates of serious side effects.

We respectfully ask that providers discuss reproductive life planning, and if appropriate, the option of immediate postpartum placement of the IUD or implant with their patients. It is suggested that these discussions take place early on, during the third trimester of pregnancy. Please provide additional counseling and support to your teenage and young patients (ages 13-19), as this group is at the greatest risk for early discontinuation of contraception. It appears that there is lower discontinuation at two years of IUDs as compared to the etonogestrel implant. When clinically appropriate, IUDs should be considered over the implant.

If you have questions regarding providing this new service to your patients, please contact Provider Services at <<1-800-454-3730 (TTY: 711)>> from <7 a.m. to 5 p.m.> Central time, Monday through Friday. You may also visit our website at <providers.amerigroup.com/ia>**.**

Health Services Programs

Health Management: Disease Management Centralized Care Unit

Our Disease Management Centralized Care Unit (DMCCU) programs are based on a system of coordinated care management interventions and communications designed to assist physicians and others in managing members with chronic conditions. The programs include a holistic, member-centric care management approach that allows case managers to focus on multiple needs of members. Our disease management programs include:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disorder (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder
- Schizophrenia
- Substance use disorder

We also offer weight management services to members with a disease management (DM) condition and a weight concern. In addition to these eleven condition-specific disease management programs, our holistic approach also allows us to manage members with multiple conditions like cerebrovascular disease, fibromyalgia and musculoskeletal complications. Please note that a member must have a qualifying DM condition in order to enroll in a program.

Program Features

- Proactive identification process
- Evidence-based clinical practice guidelines from recognized sources
- Collaborative practice models that include the physician and support providers in treatment planning
- Continuous self-management education, including primary prevention, behavior modification programs, compliance/surveillance, home visits, case management for high-risk members
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with providers regarding patient status

Amerigroup Disease Management Clinical Practice Guidelines are located at providers.amerigroup.com/ia. Simply access the Iowa state page and log in to the secure site by entering your user name and password. Select the Clinical Policy & Guidelines link on the top navigation menu. A copy of the guidelines can be printed from the website or you can contact Provider Services at <<1-800-454-3730>> to receive a copy.

Who is Eligible?

All members with the listed conditions/diagnoses are eligible for DMCCU services. Members are identified through continuous case finding efforts that include, but are not limited to, continuous case finding, welcome calls, claims mining and referrals.

DMCCU Provider Rights and Responsibilities

The provider has the right to:

- Have information about Amerigroup, including provided programs and services, our staff, and our staff's qualifications and any contractual relationships.
- Decline to participate in or work with the Amerigroup programs and services for his or her patients, depending on contractual requirements.
- Be informed of how Amerigroup coordinates our interventions with treatment plans for individual patients.
- Know how to contact the person responsible for managing and communicating with the Provider's patients.
- Be supported by the organization to make decisions interactively with patients regarding their health care.
- Receive courteous and respectful treatment from Amerigroup staff.
- Communicate complaints regarding DMCCU as outlined in the Amerigroup Provider Complaint and Grievance Procedure.

Hours of Operation

Amerigroup care managers are licensed nurses/social workers and are available from <8 a.m. to 5 p.m.> Central time, Monday through Friday. Confidential voicemail is available 24 hours a day.

Contact Information

Please call <<1-888-830-4300 (TTY: 711)>> to reach a case manager. Additional information about disease management can be obtained by visiting providers.amerigroup.com/ia and selecting **Medical** > **Disease Management Centralized Care Unit**. Members can obtain information about our DMCCU by calling <<1-888-830-4300 (TTY: 711)>>.

Health Services Programs
Health Management: Healthy Families

Healthy Families is a six-month program for children aged 7 to 17 years who are overweight, obese or at risk of becoming overweight or obese. Healthy Families includes coaching using motivational interviewing, lifestyle education and written materials to support member-identified goals. Members can be referred to the program by calling <<1-888-830-4300>>.

Health Services Programs
Health Management: Women, Infants and Children

The special supplemental nutrition program for Women, Infants and Children (WIC) serves to safeguard the health of low-income women, infants and children up to age 5 who are at nutritional risk. WIC provides nutritious foods to supplement diets, information on healthy eating, and referrals to health care.

Providers are responsible for the following:

- Identifying if a member is eligible for WIC and referring that member to the WIC program.
- Informing and educating eligible members of the availability of WIC services, including availability of food vouchers, nutrition education classes and community referrals.
- Providing written materials about WIC services in the provider's office.

Member eligibility is contingent upon meeting WIC's nutritional risk requirement, as well as the following:

- A woman who is pregnant, up to six weeks after the birth
- A woman who is breastfeeding, up to the infant's first birthday
- An infant, up to the infant's first birthday
- A child, up to the child's fifth birthday and who is at nutritional risk

The nutritional risk requirement means that an individual has medically-based or dietary-based conditions. Examples are as follows:

- Medically based conditions include anemia, underweight, or a history of poor pregnancy outcomes
- Dietary-based conditions include a failure to meet dietary guidelines or inappropriate nutrition practices

For more information about the WIC program, go to the WIC website at idph.state.ia.us/wic.

Health Services Programs
Health Education: Amerigroup On Call

We recognize that questions about health care prevention and management do not always come up during office hours. Amerigroup On Call, a phone line staffed by Registered Nurses, provides a powerful provider support system and is a component of after-hours care. Amerigroup On Call allows members to closely monitor and manage their own health by giving members the ability to ask questions whenever the need arisesAmerigroup On Call is available 24 hours a day, 7 days a week.

Phone: <1-800-600-4441>
TTY: <711>

Members may contact Amerigroup On Call Helpline for:

- Self-care information, including assistance with symptoms, medications and side-effects, and reliable self-care home treatments
- Access to specialized nurses trained to discuss health issues specific to our teenage members
- Information on more than 300 health care topics through Amerigroup On Call audio tape library

Nurses on Amerigroup On Call have access to telephone interpreter services for callers who do not speak English. All calls are confidential.

Health Services Programs
Health Education: Drug Lock-In Initiative

In conjunction with our initiative to reduce inappropriate use of the emergency room (ER), Amerigroup has developed a lock-in program to decrease inappropriate use of the ER for pain management and drug-seeking behavior. Members receive information about the primary care hospitals and pharmacies they may use to receive services and procure pharmaceuticals. Providers assigned to the member receive information on members who are assigned to the lock-in program.

Health Services Programs
Health Education: Smoking Cessation

Amerigroup supports the National Cancer Institute's health education program for members who want to quit smoking. The Smoking Cessation program's goals are to:

- Assist members in improving their health status and quality of life by becoming more actively involved in their own care

- Encourage members to quit smoking
- Offer members resources and education as a means of supporting smoking cessation efforts

The National Cancer Institute has developed a booklet called Clearing The Air. The booklet provides tips to support smoking cessation by identifying available resources and offering tools for quitting, such as:

- Winning strategies of successful quitters
- Coping skills for fighting the urge to smoke
- Strategies for success after a relapse
- National Quit Line contact information

National Quit Line: <<1-877-44U-QUIT (1-877-448-7848)>>

After enrollment, a member may request the Clearing the Air booklet by using the contact information provided in the plan's welcome packet. The member also may request the booklet by contacting Amerigroup On Call or when talking to Medical Management Nurses or Social Workers. The booklet also is available to download from the following websites:

National Cancer Institute: **https://pubs.cancer.gov**

Smokefree.gov: www.smokefree.gov

Health Services Programs

Provider Assessment of Smoking Use

The following are guidelines providers should use to help members quit smoking:

- Assess members' smoking status and offer advice about quitting.
- Use the state's online Notification of Pregnancy form as a way to notify us, through the state, of pregnant women who smoke. Women are more likely to quit smoking during pregnancy.
- Offer members resources to stop smoking, including the Clearing the Air program information from the National Cancer Institute.
- Refer members to Iowa's help line to stop smoking: <<1-800-QUIT-NOW (1-800-784-8669)>>.

CHAPTER 10: CLAIMS AND BILLING

Provider Services: **<<1-800-454-3730>>**
Provider Services Fax: **1-800-964-3627**
Hours of Operation: **Monday to Friday, 7:30 a.m.-6 p.m. Central time**

Claims and Billing
Overview

Having a fast and accurate system for processing claims allows providers to manage their practices and our members' care more efficiently. With that in mind, Amerigroup has made claims processing as streamlined as possible. Share the following guidelines with your staff, billing service and electronic data processing agents:

- Submit "clean" claims, making sure the right information is on the right form.
- Submit claims as soon as possible after providing service.
- Submit claims within the contracted filing time limit.

Providers can check claim status at www.Availity.com. Providers must register with Availity to access the secure portion of the website. Once signed up, you can log in to a single account and perform numerous administrative tasks for members covered by IA Health Link or by other selected payers. Providers may also access Availity from our website at providers.amerigroup.com/ia by selecting **Login** or **Register**. Detailed information on accessing Availity is available at www.Availity.com or on our website at providers.amerigroup.com/ia.

In this chapter, we also provide a detailed list of the following:

- Covered services
- Clinical submission categories
- Common reasons for rejected and returned claims
- Reimbursement policies

Claims and Billing
Submitting "Clean" Claims

Claims are defined as "clean" when they are submitted without any defects, with all required information required for processing and in the timely filing period.

A claim submitted with incomplete or invalid information may be returned. If you use the Electronic Data Interchange (EDI), claims will be returned for incomplete or invalid information. Claims may be returned if they are not submitted with the proper HIPAA-compliant code set. In each case, an error report would be generated and sent to the provider for claims not accepted. You and your staff are responsible for working with your EDI vendor to ensure "erred out" claims are corrected and resubmitted.

Generally, there are two types of forms you'll need for reimbursement:

- CMS-1500 for professional services: www.cms.gov/Medicare/CMS-Forms
- CMS-1450 (UB-04) for institutional services: www.cms.gov/Regulations-and-Guidance

CMS forms are located at the following link: **www.cms.gov**. These forms are available in both electronic and hard copy/paper formats.

Please note: Using the wrong form, or not filling out the form correctly or completely, causes the claim to be returned, resulting in processing and payment delays.

Claims and Billing
Methods for Submission

There are two methods for submitting a claim:

- Electronically (preferred) via and EDI vendor or web portal submission
- Paper or hard copy

Claims and Billing
Web Portal Submission

Availity's web portal offers a variety of online functions to help you reduce administrative costs, eliminate paper work and decrease phone calls. You will need to sign up to access this new portal. Once signed up, you can log in to a single account and perform numerous administrative tasks for members covered by Amerigroup or by other payers.

Claims can be submitted electronically through Availity web portal. For more information about Availity such as how to register, training opportunities and more, visit **www.Availity.com.**

Claims and Billing
Electronic Claims

Electronic filing methods are preferred for accuracy, convenience and speed. Electronic Data Interchange (EDI) allows providers and facilities to submit and receive electronic transactions from their computer systems. For questions about EDI, contact EDI Provider Services at <1-800-590-5745>.

The EDI Solutions Helpdesk can assist with any of the following:

- Learn more about EDI and how to get connected
- Submit claims electronically to Amerigroup, if your system is compatible
- Get technical assistance and support

Iowa providers have access to use any EDI clearinghouse connected to the Amerigroup Enterprise EDI Gateway. Providers have three options to submit electronic claims:

- Availity: payer ID 26375 for professional and institutional claims
- Emdeon: payer ID 27514 for professional and institutional claims
- Capario: payer ID 28804 for professional and institutional claims

If you are using another EDI vendor in Iowa please provide the information above so that the vendor can work with their affiliate EDI vendor to submit claims.

If you use EDI, submit the following provider information:

- Provider name
- Individual or group NPI, if applicable
- Federal provider tax identification number (TIN)
- Amerigroup's payer identification number

After submitting electronic claims, monitor claim status by doing the following:

- Access Availity, the secure provider portal on the **Providers** page of our website: **providers.amerigroup.com/ia.** Click on **Login** or **Register** and register or log on to access the site.
- Watch for and confirm Plan Batch Status Reports from your vendor/clearinghouse to ensure your claims have been accepted by Amerigroup.
- Correct and resubmit Plan Batch Status Reports and error reports electronically.
- Correct errors and electronically resubmit immediately to prevent denials due to late filing.

Please note: A front-end editing process may occur with your contracted EDI vendor or clearinghouse to catch mistakes. If claims are not in a HIPAA-compliant transaction code set, your claim may be "erred out" by your EDI vendor. An error report will be sent to you and your claim will not be sent through for payment. Review the error report, make the necessary changes and file again. Providers must be Iowa Medicaid certified or the claims will be rejected during the front-end editing.

Claims and Billing

Paper Claims

Paper claims are scanned for clean and clear data recording. To get the best results, paper claims must be legible and submitted in the proper format. Follow these requirements to speed processing and prevent delays:

- Use the correct form and be sure the form meets Centers for Medicare & Medicaid Services (CMS) standards.
- Use black or blue ink. Do not use red ink because the scanner may not be able to read red ink.
- Use the “remarks” field for messages.
- **Do not stamp or write over boxes on the claim form.**
- Send the original claim form to Amerigroup and retain a copy for your records.
- Do not staple original claims together; Amerigroup will consider the second claim as an attachment and not an original claim to be processed separately.
- Remove all perforated sides from the form. To help our equipment scan accurately, leave a ¼-inch border on the left and right sides of the form after removing perforated sides.
- Type information within the designated field. Be sure the type falls completely within the text space and is properly aligned.
- Do not highlight any fields on the claim forms or attachments. Highlighting makes it more difficult to create a clear electronic copy when the document is scanned.
- If using a dot matrix printer, do not use “draft mode” because the characters generally do not have enough distinction and clarity for the optical scanner to read accurately.

Submit paper claims to:

<Amerigroup Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010>

If you submit paper claims, you must include the following provider information:

- Provider name
- Rendering provider group or billing provider
- Federal provider TIN
- NPI (excluding atypical providers)

- Medicare number (if applicable)

Please note: Some claims may require additional attachments. Be sure to include all supporting documentation when submitting your claim. Claims with attachments should be submitted on paper.

After filing a paper claim, you should receive a response from Amerigroup within 30 business days after we receive the paper claim. If the claim contains all required information, Amerigroup enters the claim into the claims system for processing and sends you either a Remittance Advice (RA) or a claims disposition notice (CDN) when the claim is finalized.

Claims and Billing

National Provider Identifier

The NPI is a 10-digit, all numeric identifier. NPIs are issued only to providers of health services and supplies. As a provision of HIPAA, the NPI has been established to improve efficiency and reduce fraud and abuse. All Amerigroup participating providers must have an NPI number with the exception of atypical providers.

NPIs are divided into two types:

- **Type One**: Individual providers, including, but not limited to physicians, dentists and chiropractors
- **Type Two**: Hospitals and medical groups, including but not limited to hospitals, group practices, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Using your NPI for claims and billing has several advantages due to simplification, for example:

- Billing process: Maintaining and using legacy identifiers for each of the health care plans is no longer necessary.
- Provider changes: Modifying provider information is easier, such as changing a business address or phone number.
- Provider identification: Using a single identification number for electronic transactions with any health care plan with which they are affiliated.

National Provider Identifier (NPI) — The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the adoption of a standard unique Provider Identifier for health care Providers. All Amerigroup participating Providers must have an NPI number with the exception of Atypical Providers.

The NPI is a 10-digit intelligence-free numeric identifier. Intelligence-free means the numbers do not carry information about health care Providers, such as the state in which they practice or their specialty.

Providers may apply for a NPI online at the National Plan and Provider Enumeration System (NPPES) website: **https://nppes.cms.hhs.gov**. Or, request a paper application by calling NPPES: <<1-800-465-3203>>.

The following websites offer additional NPI information:

- CMS: **www.cms.gov**
- NPPES: **https://nppes.cms.hhs.gov**
- Workgroup for Electronic Data Interchange: **www.wedi.org/**
- National Uniform Claims Committee: **www.nucc.org**

Atypical Providers

Atypical providers include individuals or businesses that are not health care providers and do not meet the definition of a health care provider according to the NPI rules. These types of providers do not require an NPI number. Examples of atypical providers include but are not limited to:

- Home delivered meals
- Personal assistance/personal care attendant services
- Home modification/repair services
- Transportation services

Claims and Billing
Enrollment in Iowa Medicaid

To be reimbursed for services by Amerigroup, providers must successfully complete Iowa Medicaid's provider enrollment process. Providers enroll by completing an online enrollment application at www.dhs.iowa.gov/ime/providers/enrollment.

Claims and Billing
International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10 CM)

ICD-10-PCS (Procedure Coding System) is the HIPAA standard code set that replaced Volume 3 of ICD-9-CM for inpatient facility services (services billed on a UB-04 claim form) on October 1, 2015. ICD-10-PCS identifies these services by emphasizing the allocation of hospital services instead of focusing on the physician services.

Current Procedural Terminology (CPT) will continue to be HIPAA standard code set for filing either inpatient or outpatient claims for physician services (services billed on a CMS-1500 form). Note that CPT codes should continue to be filed with procedure code modifiers as appropriate.

ICD-10 resources are available through CMS at: **http://www.cms.gov/ICD10/**

Claims and Billing
Claim Filing Limits

Filing limits are determined as follows: If Amerigroup is the primary or secondary payer the time period is 90 days and is determined from the last date of service on the claim through the Amerigroup receipt date.

Claims must be submitted within the contracted filing limit to be considered for payment. Claims submitted after that time period will be denied for timely filing.

Please note: Amerigroup is not responsible for a claim never received. If a claim is submitted inaccurately, prolonged periods before resubmission may cause you to miss the filing deadline. Claims must pass basic edits to be considered received. To avoid missing deadlines, submit clean claims as soon as possible after delivery of service.

Claims and Billing
Claim Forms and Filing Limits

Refer to the provider contract to confirm the time limits to file.

Form	Type of Service to be Billed	Time Limit to File
CMS-1500 Claim Form	Physician and other professional services. Specific ancillary services, including the following: Ambulance Ambulatory surgical center Area education agencies Audiologists Birthing centers Certified registered nurse anesthetists Chiropractors Clinics Community mental health clinics Dialysis Durable medical equipment (DME) Diagnostic imaging centers Federally qualified health clinics Family planning clinics HCBS Services Hearing aid dispensers Home infusion Hospice Independently practicing physical therapists Laboratories Lead investigation agency Maternal health centers Medical equipment and supply dealers Nurse midwives Occupational therapy Opticians / optometrists Orthotics / Orthopedic shoe dealers Physical therapy Prosthetics Rural health clinics Screening centers Skilled nursing facilities (SNFs) Speech therapy Some ancillary providers may use a CMS-1450 form if they are ancillary institutional providers. Ancillary charges by a hospital are considered facility charges.	Submit within 90 days of service date.
CMS-1450 Claim Form	Hospitals, institutions and home health services.	Submit within 90 days of service date.

Claims and Billing
Other Filing Limits

Action	Description	Time Frame
Third-Party Liability or Coordination of Benefits (COB)	If the claim has third-party liability, COB, or requires submission to a third party before submitting to Amerigroup, the filing limit starts from the date of service.	90 days from the date of the explanation of payment (EOP)
Checking Claim Status	Check claim status at any time by calling Provider Services or accessing our secure Provider portal, Availity, through our website at providers.amerigroup.com/ia. Refer to the *Monitoring Submitted Claims* section of this chapter for details.	
Claim Follow-Up	To submit a corrected claim after Amerigroup requests additional information or a correction to a claim.	Return the requested information within 90 days of the date of the request.
Provider Dispute	To request a claim appeal, send your request in writing to: Amerigroup Iowa P.O. Box 61599 Virginia Beach, VA 23466-1599	Submit within 120 days of receipt of Amerigroup's remittance advice (RA) of the notice of action.
Retro Eligible Members	In instances where a member is made retro-eligible to Amerigroup, the provider must submit the claims within 90 days of the date that they are made retro-eligible. However, the provider is responsible for obtain and authorization for any services on a go forward basis.	Submit the claim within 90 days of the date the member is made retro eligible. The claims may deny for timely filing initially but contact your provider relations representative for assistance if needed in these circumstances or contact Provider Services.

Claims and Billing
Claims from Non-contracted Providers

The filing limit for out-of-network provider submissions of claims to the contractor is 12 months from the date of service. This conforms with the filing limit under the Medicaid state plan (42 C.F.R. § 447.45(d)(4)).

Amerigroup accepts the following claims from non-contracted providers under certain conditions and within certain time frames:

- Emergency services: 365 days from date of service or discharge date
- Medicaid enrolled: 365 days with precertification if services are not available in Iowa
- Newly Medicaid enrolled: Within 365 days of the date the new provider identifier is issued, and within 365 days of the date of service

Claims and Billing
Member Copayments and Balance Billing

Providers contracted with Amerigroup may not balance bill members for covered services above the amount Amerigroup pays to the provider.

Providers may balance bill a member when precertification of a covered service is denied; The provider must establish and demonstrate compliance with the following:

- Establish that precertification was requested and denied before rendering service.
- Request a review of the authorization decision made by Amerigroup.
- Notify the member that the service requires precertification and that Amerigroup has denied authorization. If out-of-network, the provider also must explain to the member that covered services may be available without cost when provided by an in-network provider. In such cases, precertification of service is required.
- Inform the member of his or her right to file a grievance if the member disagrees with the decision to deny authorization.
- Inform the member of his or her responsibility for payment of nonauthorized services.
- If the provider uses a waiver to establish member responsibility for payment, the waiver must meet the following requirements:
  - The waiver is signed only after the member receives appropriate notification and before services are rendered
  - The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment
  - A waiver must be obtained for each encounter or member visit that falls under the scenario of the noncovered services. Providers may not use nonspecific patient waivers
  - The waiver must specify the date services were provided and which services fall under the waiver's application
  - The waiver must show the cost of the services and have a payment plan established
- The provider has the right to appeal a denial of Amerigroup payment resulting from a denial of authorization.

Claims and Billing
Member Liability / Client Participation

Some members have a member liability, also referred to as client participation, which must be met before Medicaid reimbursement for services is available. DHS has the responsibility for determining the member liability amount. This includes a portion of members eligible for Medicaid on the following bases: (i) members in an institutional setting; and (ii) 1915(c) HCBS waiver enrollees. Through the DHS eligibility and enrollment files, the State will notify Amerigroup of any applicable member liability amounts. This information will be made available to providers. Providers will be required to collect this amount from the member. Provider will bill gross / full charges. Amerigroup will adjudicate the claim and deduct the patient liability amount. In the event the sum of any applicable third-party payment and a member's financial participation equals or exceeds the reimbursement amount established for services, Amerigroup will make no payment to the provider.

Claims and Billing
Coordination of Benefits

If a member carries insurance through multiple insurers, Amerigroup will coordinate the benefits to ensure maximum coverage without duplication of payments. Providers must submit coordination of benefits (COB)

claims to the primary carrier before submitting to Amerigroup. After submitting the claim to the primary carrier, submit a claim for the total billed charges to Amerigroup along with a copy of the primary carrier's RA. Indicate the *Other Coverage* information on the appropriate claim form. If you need to coordinate benefits, include at least one of the following items from the other health care program:

- Third-party RA
- Third-party letter explaining either the denial of coverage or reimbursement

COB claims received without at least one of these items will be mailed back to you with a request to submit to the other health care program first. Make sure the information you submit explains all coding listed on the other carrier's Remittance Advice or letter. We cannot process the claim without this information.

Claims and Billing
Subrogation

Amerigroup follows the State of Iowa's subrogation laws as cited in the Administrative Code DHS 106.03(8): Personal injury and workers' compensation claims: If a provider treats a recipient for injuries or illness sustained in an event for which liability may be contested or during the course of employment, the provider may elect to bill Medicaid for services provided without regard to the possible liability of another party or the employer. Alternatively, the provider may elect to seek payment by joining in the recipient's personal injury claim or workers' compensation claim, but in no event may the provider seek payment from both Medicaid and a personal injury or workers' compensation claim. After the provider accepts the Medicaid payment for services provided to the recipient, the provider shall not seek or accept payment from the recipient's personal injury or workers' compensation claim.

Providers must choose which method of payment they will pursue at the time of treatment and submit claims either to Amerigroup or to the member's personal injury/workers' compensation carrier. The law does not allow providers to submit claims to both carriers. If a provider submits to both carriers, receives payment from both carriers, and subsequently sends a refund to Amerigroup, submission of the refund still could be considered a fraudulent action. Seeking or accepting payment from both carriers is prohibited by law.

Amerigroup agrees to first pay the provider and then coordinate with the liable third party. We will not require providers to bill the third party prior to Amerigroup in the following situations: (i) the claim is for prenatal care for a pregnant woman; (ii) the claim is for coverage derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency and the provider of service has not received payment from the third party within 30 calendar days after the date of service; or (iii) the claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program. Following reimbursement to the provider in these cost avoidance exception cases, we will actively seek reimbursement from responsible third parties and adjust claims accordingly.

Claims and Billing
Claims Filed With the Wrong Plan

If you file a claim with the wrong insurance carrier, Amerigroup will process your claim within 90 days from the date of service. If the claim or claim dispute includes an explanation for the delay or other evidence that establishes the reason, Amerigroup will determine good cause based primarily on that statement or evidence and/or if the evidence leads to doubt about the validity of the statement. Amerigroup will contact the provider for clarification or additional information necessary to make a good cause determination

Claims and Billing

Payment of Claims

After filing a paper or electronic claim, you should receive a response from Amerigroup within 30 business days after we receive the claim. If the claim contains all required information, Amerigroup enters the claim into the claims system for processing and sends you either a remittance advice (RA) or a Claims Disposition Notice (CDN) when the claim is finalized.

Amerigroup will finalize a clean electronic or paper claim within 21 days from the date the claim is received.

A "clean claim" is one in which all information required for processing is present. If a claim is denied because more information was required to process the claim, the claim denial notice shall specifically describe all information and supporting documentation needed to evaluate the claim for processing.

Claims and Billing

Monitoring Submitted Claims

After submitting paper or electronic claims, you can monitor and make changes to the claim by:

- Checking claim status on the secure provider portal on the **Providers** page of our website: **providers.amerigroup.com/ia.** Click on **Login** or **Register** and register or log on to access the site. For directions on how to access the **Providers** page of our website, please see **Chapter 1: How to Access Information, Forms and Tools on Our Website**.
- Calling Provider Services
- Confirming receipt of Plan Batch Status Reports from your vendor/clearinghouse to ensure claims have been accepted by Amerigroup
- Correcting and resubmitting Plan Batch Status Reports and error reports electronically
- Correcting errors and immediately resubmitting to prevent denials due to late filing

Claims and Billing

Electronic Fund Transfer

Amerigroup allows Electronic Funds Transfer (EFT) for claims payment transactions, meaning that claims payments are deposited directly into a previously selected bank account. Enroll in this service by calling Provider Services at <<1-800-454-3730>>.

Claims and Billing

Electronic Remittance Advice

Amerigroup providers can choose to receive electronic remittance advices (ERAs). ERAs are received through an electronic mailbox that has been set up between Amerigroup, the provider and/or the provider's clearinghouse. For more information, please call Provider Services at <<1-800-454-3730>>.

Claims and Billing

Claims Overpayment Recovery Procedure

Refund notifications may be identified by two entities, Amerigroup and its contracted vendors, or the providers. If Amerigroup identifies the refund notification, we will research and notify the provider of an

overpayment, and request a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Amerigroup, Amerigroup will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment.

If a provider identifies an overpayment and submits a refund, a completed Refund Notification form specifying the reason for the return must be included. This form can be found on the provider website at providers.amerigroup.com/ia. The submission of the Refund Notification Form will allow Cost Containment to process and reconcile the overpayment in a timely manner. The provider can also complete a Recoupment Notification form, which gives Amerigroup the authorization to adjust claims and create claim offsets. This form can also be found on the provider website at providers.amerigroup.com/ia. For questions regarding the refund notification procedure or recoupment process, please call Provider Services at <<1-800-454-3730>>.

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. Amerigroup will determine the cumulative adjusted reimbursement amount based on the new rates. In the event the outcome of this reconciliation results in a net amount owed to Amerigroup, Amerigroup will work with the provider and provide the appropriate notice prior to commencement of any recovery activities including through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

Changes addressing the topic of overpayments have taken place with the passage of the Patient Protection and Affordable Care Act (PPACA), commonly known as the Healthcare Reform Act.

The provision directly links the retention of overpayments to false claim liability.

The language of 42 U.S.C.A. § 1320a-7k makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment, or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act, including treble damages. In order to avoid such liability, health care providers and other entities receiving reimbursement under Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

Provision 42 U.S.C.A. § 1320a-7k, entitled “Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments,” clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act.

This provision of the HealthCare Reform Act applies to providers of services, suppliers and Medicaid MCOs.

Claims and Billing

Third-Party Recovery

Providers may not interfere with or place any liens upon the rights of the State of Iowa or Amerigroup, acting as Iowa’s agent, to recovery from third-party billing.

Claims and Billing
Claim Resubmissions

If you have not heard from Amerigroup regarding a submitted claim after 30 business days from the submission of the claim, contact us to determine the status. To determine whether you need to resubmit a claim:

- Check the secure provider portal on the **Providers** page of our website: providers.amerigroup.com/ia**.** Click on **Login** or **Register** to access the site. For directions on how to access the **Providers** page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.
- Contact Provider Services at <<1-800-454-3730>>.

Claims and Billing
Claims Returned for Additional Information

Amerigroup will send you a request for additional or corrected information when the claim cannot be processed due to incomplete, missing or incorrect information. Amerigroup also may request additional information retroactively for a claim already paid. If you receive a request from Amerigroup for additional information, you must provide that information within 60 days of the date of the request or your claim may be denied.

To submit additional or corrected information, you must send:

- All supporting documentation you believe to be important or that is specifically requested by Amerigroup
- A copy of the original, corrected CMS-1500 or CMS-1450 claim form

Please note: Many of the claims returned for further information are returned for common billing errors.

Claims and Billing
Claims Payment Appeals

If you do not agree with the outcome of a claim decision, use the claims payment appeals process to challenge the decision. Submit requests for claims payment appeals in writing to Amerigroup within 60 days of the date you receive Amerigroup's RA or payment voucher. Include all pertinent information, such as:

- Cover letter with all points of contention itemized and explained
- Copy of the original or corrected CMS-1500 or CMS-1450 claim form
- Supporting documentation deemed pertinent or requested by Amerigroup

Mail the cover letter and supporting documentation to:

Payment Dispute Unit
Amerigroup Iowa, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599

Claims and Billing
Timeline for Claims Payment Appeals

Claims payment appeals are resolved within 60 days of receipt of the written request. When we uphold or overturn a previous claim disposition, a resolution letter with the details of our decision is sent to the provider. If a provider is not satisfied with the outcome of the review process or if we do not respond to an appeal within 60 days, additional steps may be taken:

- Providers may appeal to the Iowa DHS in writing within 60 days of the final decision by the Amerigroup or within 60 days from the 60 day timeline allotted Amerigroup to respond.
- Providers may use the Iowa DHS form when submitting the appeal for DHS review. All elements of the form must be completed when submitting the form, including medical records for an appeal regarding medical necessity.

The Iowa DHS form is available at the following website:

http://dhs.iowa.gov/appeals/appeal-a-dhs-decision

If you are writing a letter or you do not want to complete this form on-line, you can send or take your appeal request to your local office or you can submit it directly to the Appeals Section at:

Iowa Department of Human Services Appeals Section
1305 E Walnut Street, 5th Fl
Des Moines, IA 50319
Phone: <<515-281-3094>>
Fax: <<515-564-4044>>
Email: appeals@dhs.state.ia.us>

Claims and Billing
Reference: Covered Services

For a listing of covered services, please see **Chapter 4 – Covered and Noncovered Services**.

Claims and Billing
Reference: Clinical Submissions Categories

The following is a list of claims categories for which we routinely may require submission of clinical information before or after payment of a claim. If the claim:

- Involves precertification, predetermination or some other form of utilization review, including- but not limited to, claims that are:
  - Pending for lack of precertification
  - Involving medical necessity or experimental/investigative determinations
  - Involving drugs administered in a physician's office requiring precertification
- Requires certain modifiers
- Includes unlisted codes
- Is under review to determine if the service is covered. Benefit determination cannot be made without reviewing medical records. This category includes, but is not limited to, specific benefit exclusions
- Involves termination of pregnancy: All termination of pregnancy claims require review of medical records to determine if the pregnancy is the result of an act of rape or incest. Or, in cases where the woman suffers from a physical disorder, physical injury, or physical illness, including a physical

condition that endangers the woman's life and is caused by or arising from the pregnancy itself. This condition would, as certified by a provider, place the woman in danger of death unless a termination of pregnancy is performed

- Involves possible inappropriate or fraudulent billing
- Is the subject of an internal or external audit, including high-dollar claims
- Involves individuals under case management or disease management
- Is under appeal or is otherwise the subject of a dispute, including claims being mediated, arbitrated or litigated

Other situations in which clinical information might be requested:

- Accreditation activities
- Coordination of benefits
- Credentialing
- Quality improvement/assurance efforts
- Recovery/subrogation
- Requests relating to underwriting, including, but not limited to, member or provider misrepresentation/fraud reviews and stop-loss coverage issues

Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

Claims and Billing

Reference: Common Reasons for Rejected and Returned Claims

Many of the claims returned for further information are returned for common billing errors.

Problem	Explanation	Resolution
Member's Identification (ID) Number is Incomplete		Use the Member's ID number on the IA Health Link card.
Duplicate Claim Submission	Overlapping service dates for the same service create a question about duplication. Claim was submitted to Amerigroup twice without additional information for consideration.	List each date of service, line by line, on the claim form. Avoid spanning dates, except for inpatient billing. Read RAs and CDNs for important claim determination information before resubmitting a claim. Additional information may be necessary.
Missing Codes for Required Service Categories	Current Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) manuals must be used because changes are made to the codes quarterly or annually. Manuals may be purchased at any technical bookstore, or through the American Medical Association (AMA) or the Practice Management Information Corporation.	Verify all services are coded with the correct codes (see lists provided). Check the codebooks or ask someone in your office who is familiar with coding.
Unlisted Code for Service	Some procedures or services do not have an associated code; use an unlisted procedure code.	Amerigroup needs a description of the procedure and medical records to calculate reimbursement. DME, prosthetic devices, hearing aids or blood products require a manufacturer's invoice. For drugs/injections, the National Drug Code (NDC) number is required.
By Report Code for Service	Some procedures or services require additional information.	Amerigroup needs a description of the procedure and medical records to calculate reimbursement. DME, prosthetic devices, hearing aids or blood products require a manufacturer's invoice. For drugs/injections, the NDC number is required.

Problem	Explanation	Resolution
Unreasonable Numbers Submitted	Unreasonable numbers, such as "9999", may appear in the Service Units fields.	Check your claim for accuracy before submission.
Submitting Batches of Claims	Stapling claims together may make the subsequent claims appear to be attachments, rather than individual claims.	Clearly identify each individual claim and do not staple to another claim.

Claims and Billing

Reimbursement Policies

Reimbursement policies serve as a guide to assist you with accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. These policies can be accessed at providers.amerigroup.com/ia. The determination that a service, procedure or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claims submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the service and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding guidelines, billing guidelines or current reimbursement policies are not followed, Amerigroup may:

- Reject or deny the claim
- Recover and/or recoup the claim payment

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider or state contracts, or state, federal, or CMS requirements. System logic or set up may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

We reserve the right to review and revise our policies periodically when necessary. When there is an update we will publish the most current policies to our provider website under the Quick Tools menu.

Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity, authorization requirements or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Review Schedules and Updates

Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to an

Amerigroup business decision. When there is an update we will publish the most current policies to our provider website under the Quick Tools menu.

Reimbursement by Code Definition

Amerigroup allows reimbursement for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections unless otherwise noted by state or provider contracts, or state, federal or CMS requirements. There are seven CPT sections:

1. Evaluations and management
2. Anesthesiology
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Temporary codes for emerging technology, services or procedures

At times, procedure codes are located in particular CPT categories when those procedures may not, as a general understanding, be classified within the particular category (e.g., venipuncture is located in the CPT surgical section but is not considered to be a surgical procedure).

Provider Reimbursement and Fee Schedules

Amerigroup reimburses providers based on state Medicaid reimbursement methodologies and monitors the state website for any changes in fee schedules. Upon notification either by the state or through monitoring of the state website then Amerigroup would initiate the steps needed to update our systems to implement fee schedule and reimbursement changes.

Where the state does not have a rate established then Amerigroup will use CMS methodologies as applicable to establish a rate.

Fee schedule providers include the following:

- Ambulance
- Ambulatory surgical
- Audiologist
- BHIS
- Birthing center
- Certified nurse mid-wife
- Certified registered nurse anesthesiologist
- Chiropractor
- Clinic
- Community mental health center
- Durable medical equipment
- Family planning clinic
- Habilitation service
- Hearing aids
- Lead investigation
- Maternal health
- Nurse practitioner
- Optician
- Optometrist
- Primary care
- Podiatrist
- Psychologist
- Rehabilitation agency and independent therapists
- Specialists
- Screening center
- HCBS

Claims and Billing

Acute Care Hospitals / Critical Access Hospitals

Inpatient Services:

Inpatient payment is based on the Prospective Payment System (PPS), which uses provider specific diagnostic related group (DRG) base rates. The base rate is multiplied by the Iowa-specific DRG weight to determine the final payment.

- DRG payment = DRG provider specific base rate x DRG weight

Graduate medical education (GME) will be a flat rate add-on based on a provider specific payment rate.

Cost Outliers:

An inpatient claim qualifies for a cost outlier payment when costs of service (not including any add-on amounts for direct or indirect medical education or for disproportionate-share costs) exceed the cost threshold. This cost threshold is the greater of either:

- Two times the statewide average DRG payment for that case
- The hospital's individual DRG payment for that case plus $16,000.

Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established for the case.

Long Stay Outlier:

Reimbursement for long-stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day threshold. Payment for long-stay outliers is made at 100 percent of the calculated amount when the claim is originally filed for DRG payment.

Short Stay Outlier:

Short-stay outliers are incurred when a member's length of stay is greater than two standard deviations below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short-stay outliers is 200 percent of the average daily rate for each day the member qualifies, up to the full DRG payment.

Outpatient Services:

Outpatient reimbursement is based on the ambulatory payment classification (APC) payment. The APC payment is calculated by multiplying the applicable APC relative weight by the provider specific APC rate. The APC payment is multiplied by a discount factor percent and by the units of service when applicable.

Hospital Outlier Payment Requests

Cost outlier requests must be submitted to Amerigroup for review within 90 days from the date of the explanation of payment (EOP) of the initial DRG payment for both participating and nonparticipating hospitals. The request must include supporting information, including medical records, as indicated below:

Iowa Hospital Request Checklist	Items to Provide
1	Outlier appeal cover letter naming the hospital contact person (make sure to indicate on the cover letter that this is regarding an IA Outlier Request)
2	Copy of the original claim
3	Copy of the paid remittance(s) advice (“RA”)
4	Detailed itemized charges with revenue codes
5	Charges documented on itemized bill that correlate with UB-04 claim
6	Itemized bill numbered by provider and quantities billed
7	Check that total charges and DOS match on itemized bill, RA and UB-04
8	Charges documented in the itemized bill but not billed on the UB-04 are identified and marked through on the itemized bill.
9	Utilization review notes documenting severity of illness and intensity of service criteria met; notes signed and dated
10	Physician discharge summary
11	Physician orders
12	Operating room procedure notes (if applicable)
13	Physical/occupational/speech/radiology orders/respiratory therapy notes (if applicable)
14	Chart organized and labeled for review. (Please do not include tabs or insert tabs; however, it is acceptable to insert a page indicating documents that will proceed.)
15	Other documents (e.g. laboratory reports, anesthesiology records, etc.)
16	Request submitted within deadline of paid remittance advice
17	Indicate total number of pages submitted for review

NOTE: The outlier request submissions must include **all** of the documentation detailed above for proper consideration.

Upon receipt, the outlier request of the hospital is reviewed to see if it initially meets the requirements for outlier review. The request must be submitted within the timelines stated above. It must meet the threshold requirements for the DRG under which the claim is computed, and it is processed to pay the initial DRG payment. If the request meets the qualifications, then all the information provided by the hospital is forwarded to a vendor contracted by Amerigroup for a forensic review.

Upon the review, a response with the applicable supporting documents is sent to the provider that submitted the outlier request. The forensic review lists the categories of the exceptions with exhibits providing line item details in the particular areas or revenue codes as applicable.

If the provider disagrees with the review that was performed based on the documents that were received with the initial request, the following will apply:

- Outliers that do not meet the threshold of the reviewed documentation and have no additional payment can be appealed within 30 days of the date of the letter sent to the provider. The appeal must include any additional supporting documentation and the reason for the second-level appeal.
- Outliers that have reduced charges and an outlier payment being paid to the hospital can be appealed within 30 days of the date of the EOP. The appeal must include any additional supporting documentation and the reason for the second-level appeal.

Requests can be sent to Amerigroup to the attention of:

Health Plan Operations Department
Attn: Outlier Requests
4800 Westown Parkway, Suite 100
West Des Moines, IA 50309

If you have questions, please contact Provider Services team at 1-800-454-3730, or the contact that is listed on the letter with the outlier review results and findings.

Claims and Billing
Ambulatory Service Center

Reimbursement is based on the ambulatory service center (ASC) fee schedule. Each procedure code is assigned to one of the nine ASC levels. Each of the nine levels is assigned to a separate reimbursement fee.

If multiple procedures are medically necessary, payment will be made to the ASC procedure that is the most costly according to the fee schedule. The secondary ASC procedure will be paid at XX percent of the fee for that procedure.

Claims and Billing
Behavioral Health Facility

Services are reimbursed based on the Behavioral Health Fee Schedule or per diems as defined by state reimbursement.

Claims and Billing

Federally Qualified Health Center (FQHC) and Rural Health Clinics (RHC)

Reimbursement is based on Prospective Payment System (PPS) rates.

Claims and Billing

Intermediate Care Facility

Reimbursement is based on a per diem rate that is derived from a cost based provider specific case mix adjusted rate.

Claims and Billing

Skilled Nursing Facility

Reimbursement is based on a per diem rate that is derived from a cost based provider specific case mix adjusted rate. Provider assessment pass-through payment and add-on amount will be included in the reimbursement.

CHAPTER 11: BILLING PROFESSIONAL AND ANCILLARY CLAIMS

Provider Services: **<<1-800-454-3730>>**
Provider Services Fax: **<<1-800-964-3627>>**
Hours of Operation: **Monday to Friday, 7:30 a.m.-6 p.m. Central time**

Billing Professional and Ancillary Claims

Overview

Providers can depend on efficient claims handling and faster reimbursement when they follow the Amerigroup professional and ancillary billing requirements. These requirements include using industry standardized codes for most health services. This chapter is broken down into health service categories to help you find the specific billing requirements and codes you will need for each.

You also will find information on billing members for services that are not medically necessary or not covered, billing for services for which the member is willing to pay, as well as information about completing the CMS-1500 claim form.

To help you navigate the various billing requirements and codes, we have organized the service categories as follows:

- Adult preventive care
- Behavioral health
- Emergency services
- Family planning services
- Hospital readmission policy
- Hysterectomies
- Immunizations covered by the Vaccines For Children (VFC) program
- Initial health assessments (IHAs)
- Maternity services
- Newborns
- Preventive medicine services: new patient
- Preventive medicine services: established patient
- Sensitive services
- Sterilization
- Termination of pregnancy

For the most efficient claims processing, accurately completed claims are essential. Follow these general guidelines for claims filing:

- Indicate the provider's NPI number in Box 24J of the CMS-1500 form when appropriate. Missing or invalid numbers may result in nonpayment.
- Submit only state certified NPIs.
- Use the member's identification number from the IA Health Link ID card.
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) may put their billing/group NPI number in Box 24J and 33.

Billing Professional and Ancillary Claims
Coding

To process claims in an orderly and consistent manner, we use standardized codes. The Healthcare Common Procedure Coding System (HCPCS), sometimes referred to as National Codes, provides coding for a wide variety of services.

The principal coding levels are referred to as Level I and Level II:

- Level I: Current Procedural Terminology (CPT) codes maintained by the American Medical Association (AMA) and represented by five numeric digits.
- Level II: Codes that identify products, supplies and services not included in the CPT codes, such as ambulance supplies and durable medical equipment (DME). Level II codes sometimes are called the alphanumeric codes because they consist of a single alphabetical letter followed by four numeric digits.

In some cases, two-digit/character modifier code(s) should accompany the Level I or Level II coding.

Reference guides useful for coding claims are:

- The CPT manual published by the AMA. To order, call: <<1-800-621-8335>>.
- The HCPCS published by the CMS. To order, call: <<1-800-621-8335>>**.**

Billing Professional and Ancillary Claims
Initial Health Assessments

Amerigroup's primary medical groups (PMGs) function as a member's "health home". For that reason, we encourage our members to request an Initial Health Assessment (IHA) as soon as possible after enrollment. The IHA should consist of a complete history, a physical exam and preventive services.

When billing for IHAs, use the following International Classification of Diseases (ICD) diagnosis codes:

- Codes: Z00.121- Z00.129 for children (newborn to 18 years old)
- Codes: Z00.00-Z00.01 for adults (19 years and older)

Billing Professional and Ancillary Claims
Adult Preventive Care

The following is a list of codes specific to adult preventive care. Reimbursement is subject to change based on Iowa's Medicaid Fee Schedule:

HCPCS/CPT	Description
76090/76091/76092	Mammogram
82270	Fecal occult blood test (lab procedure code only)
82465	Total serum cholesterol (lab procedure code only)

HCPCS/CPT	Description
84153	PSA (lab procedure code only)
86580	Tuberculosis (TB) screening (PPD)
88150	Pap smear (lab procedure code only)
90658	Flu shot
90718	Td-Diphtheria–Tetanus Toxoid–0.5 ml
90732	Pneumovax

Billing Professional and Ancillary Claims
Preventive Medicine Services: New Patient

Preventive medicine services for a new patient include an initial, comprehensive preventive medical evaluation. This evaluation includes an age- and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory and diagnostic procedures. Reimbursement is subject to change based on the Iowa Medicaid Fee Schedule.

HCPCS/CPT	Description
99381	Infant (under 1 year)
99382	Early childhood (ages 1-4)
99383	Late childhood (ages 5-11)
99384	Adolescent (ages 12-17)
99385	Ages 18-39
99386	Ages 40-64
99387	Ages 65 and older

Billing Professional and Ancillary Claims
Preventive Medicine Services: Established Patient

Preventive medicine services for an established patient involve re-evaluation and management of existing conditions, if any. This exam includes an age- and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory and diagnostic procedures. Reimbursement is subject to change based on the Iowa Medicaid Fee Schedule.

HCPCS/CPT	Description
99391	Infant (under 1 year)
99392	Early childhood (ages 1-4)
99393	Late childhood (ages 5-11)
99394	Adolescent (ages 12-17)
99395	Ages 18-39
99396	Ages 40-64
99397	Ages 65 and older

Billing Professional and Ancillary Claims
Behavioral Health

Bill all claims for behavioral health services to Amerigroup. See **Chapter 4: Covered and NonCovered Services** in this manual for more detailed information about behavioral health benefits. Amerigroup Behavioral Health has contracted with a network of hospitals, group practices and independent behavioral health providers to offer behavioral health services to our members. When rendering medically necessary behavioral health services, please bill Amerigroup using behavioral health CPT codes.

Billing Professional and Ancillary Claims
Emergency and Related Professional Services

Emergency services, as defined by state and local law, the Provider Agreement and our Member Handbook, are reimbursed in accordance with the Amerigroup Provider Agreement.

Please note: Precertification is not required for medically necessary emergency services.

Emergency: Any condition manifesting itself by acute symptoms of sufficient severity such that a layperson possessing an average knowledge of health and medicine could reasonably expect that the absence of immediate medical care could:

- Place the member's health in serious jeopardy. Or, with respect to a pregnant woman, the health of the woman and her unborn child
- Cause serious impairment to bodily functions
- Cause serious dysfunction to any bodily organ or part

Covered emergency services include:

- Hospital-based emergency department services (room and ancillary) needed to evaluate or stabilize the emergency medical or behavioral health condition
- Services by emergency providers

All members should be referred back to their PCP for follow-up care. Unless clinically required, follow-up care should never occur in a hospital emergency room.

Hospitals will be reimbursed for emergency services billed with the following codes. Reimbursement of CPT codes is subject to change based on the Iowa Medicaid Fee Schedule:

- 99284
- 99285
- 99281
- 99282
- 99283

Billing Professional and Ancillary Claims

Family Planning Services

The following is a list of diagnostic codes specific to family planning services:

ICD-10	Description
T8331XA	Breakdown (mechanical) of intrauterine contraceptive device, initial encounter
T8332XA	Displacement of intrauterine contraceptive device, initial encounter
T8339XA	Other mechanical complication of intrauterine contraceptive device, initial encounter
Z920	Personal history of contraception
Z30011	Encounter for initial prescription of contraceptive pills
Z30018	Encounter for initial prescription of other contraceptives
Z30019	Encounter for initial prescription of contraceptives, unspecified
Z3009	Encounter for other general counseling and advice on contraception
Z30430	Encounter for insertion of intrauterine contraceptive device
Z302	Encounter for sterilization
Z308	Encounter for other contraceptive management
Z3040	Encounter for surveillance of contraceptives, unspecified
Z3041	Encounter for surveillance of contraceptive pills
Z30431	Encounter for routine checking of intrauterine contraceptive device
Z3049	Encounter for surveillance of other contraceptives
Z3042	Encounter for surveillance of injectable contraceptive

ICD-10	Description
Z3049	Encounter for surveillance of other contraceptives
Z308	Encounter for other contraceptive management
Z309	Encounter for contraceptive management, unspecified
Z310	Encounter for reversal of previous sterilization
Z3189	Encounter for other procreative management
Z3142	Aftercare following sterilization reversal
Z3161	Procreative counseling and advice using natural family planning
Z3169	Encounter for other general counseling and advice on procreation
Z9851	Tubal ligation status
Z9852	Vasectomy status
Z3181	Encounter for male factor infertility in female patient
Z3182	Encounter for Rh incompatibility status
Z3183	Encounter for assisted reproductive fertility procedure cycle
Z3184	Encounter for fertility preservation procedure
Z3189	Encounter for other procreative management
Z319	Encounter for procreative management, unspecified
Z975	Presence of (intrauterine) contraceptive device

The following is a list of self-referable family planning codes payable without precertification requirements. Reimbursement is subject to change based on the Iowa Medicaid Fee Schedule.

HCPCS/CPT	Description
00840	Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy
00851	Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy, tubal ligation/transaction
00921	Anesthesia for intraperitoneal procedures in lower abdomen, including urinary tract, vasectomy, unilateral or bilateral
11976	Norplant removal

HCPCS/CPT	Description
11981	Insertion, non-biodegradable drug delivery implant
55250	Vasectomy
57170	Diaphragm fitting
58300	IUD insertion
58301	IUD removal only
58600	Ligation or transection of fallopian tubes, abdominal or vaginal approach, unilateral or bilateral
58615	Occlusion of fallopian tubes by device (for example, band, clip, Falope ring), vaginal or suprapubic approach
81025	Pregnancy test
84703	Chorionic gonadotropin assay
89320	Semen analysis; complete (volume, count, motility and differential)
J7300	Intrauterine copper contraceptive
J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies

Billing Professional and Ancillary Claims

Immunizations Covered By Vaccines for Children

Amerigroup providers who administer vaccines to children 0-18 years of age may enroll in the VFC program. Amerigroup will reimburse only the administration fee for any vaccine available through the VFC program.

When billing immunizations, use the CMS-1500 form and do the following:

- In box 23, insert the PCP name
- On a line of Box 24D, use the appropriate CPT code
- On another line of Box 24D, use the appropriate administration procedure code (90471 through 90474)

The following immunizations are covered under the VFC program. Reimbursement for the administration is subject to change based on the Iowa Medicaid Fee Schedule:

HCPCS/CPT Code	Description

HCPCS/CPT Code	Description
90632	Hepatitis A vaccine, adult dosage, for intramuscular use
90633	Hepatitis A vaccine, pediatric/adolescent dosage - 2-dose schedule, for intramuscular use
90636	Hepatitis A and Hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
90645	Haemophilus influenza b vaccine (Hib), HbOC conjugate (4-dose schedule), for intramuscular use
90647	Haemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3-dose schedule), for intramuscular use
90648	Haemophilus influenza b vaccine (Hib), PRP-T conjugate (4-dose schedule), for intramuscular use
90649	HPV (Gardasil) vaccine for members age 9-26
90655	Influenza virus vaccine, split virus, preservative free, for children 6–35 months of age, for intramuscular use
90657	Influenza virus vaccine, split virus, for children 6–35 months of age, for intramuscular use
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
90669	Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, for intramuscular use
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), for use in individuals younger than 7 years, for intramuscular use
90702	Diphtheria and tetanus toxoids (DT) adsorbed, for use in individuals younger than 7 years, for intramuscular use
90703	Tetanus toxoid absorbed, for intramuscular use
90705	Measles virus vaccine, live, for subcutaneous use
90706	Rubella virus vaccine, live, for subcutaneous use
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
90710	Measles, mumps, rubella and varicella vaccine (MMRV)

HCPCS/CPT Code	Description
90712	Poliovirus vaccine, any types (OPV), live, for oral use
90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use
90714	Tetanus and diphtheria toxoids (Td) absorbed, preservative free, for use in individuals 7 years or older, for intramuscular use
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (TdaP), for use in individuals 7 years or older, for intramuscular use
90716	Varicella virus vaccine, live, for subcutaneous use
90718	Tetanus and diphtheria toxoids (Td) adsorbed, for use in individuals 7 years or older, for intramuscular use
90720	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Haemophilus influenza b vaccine (DTP-Hib), for intramuscular use
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Haemophilus influenza b vaccine (DtaP-Hib), for intramuscular use
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immuno-suppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine (any groups), for subcutaneous use
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90743	Hepatitis B vaccine, adolescent (2-dose schedule), for intramuscular use
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3-dose schedule), for intramuscular use
90746	Hepatitis B vaccine, adult dosage, for intramuscular use
90748	Hepatitis B and Haemophilus influenza b vaccine (HepB-Hib), for intramuscular use

Modifier	Description

Modifier	Description
SK	Members of high-risk population

Billing Professional and Ancillary Claims
Immunizations Coding

When billing for immunizations, use the CMS-1500 form and do the following:

- On a line of Box 24D, use the appropriate CPT code
- On another line of Box 24D, use the appropriate administration procedure code

Billing Professional and Ancillary Claims
Maternity Services

Amerigroup will reimburse up to the maximum amount of the appropriate prenatal package when a provider bills for the following:

- Individual obstetrics visits
- Delivery care
- Postpartum care

Amerigroup requires itemization of maternity services when submitting claims for reimbursement. Please use the CMS-1500 claim form with the appropriate CPT and HCPCS codes, along with ICD diagnosis codes. Also include the applicable Evaluation and Management (E&M) code and coding for all other procedures performed.

Maternity billing requirements are as follows:

- Bill separately all laboratory, pregnancy tests and radiology services provided during pregnancy within the contract filing limit.
- Use the appropriate E&M, antepartum or postpartum, and CPT codes necessary for appropriate reimbursement. Indicate the estimated date of confinement (EDC) in Box 24D of the CMS-1500 claim form.
- If a member is admitted to the hospital during the course of her pregnancy, the diagnosis necessitating the admission should be the primary diagnosis on the claim.
- If a pregnancy is high-risk, document the high-risk diagnosis on the claim form.
- Identify the nature of a high-risk care visit in the diagnosis field in Box 21 of the CMS-1500 claim form, or in the appropriate field.
- Use the CMS-1500 claim form with itemized E&M codes.

Billing Professional and Ancillary Claims
Maternity Services: Newborns

Request your patients to take these important steps as soon as their babies are born:

- Immediately contact the Iowa DHS or their social worker to request the required paperwork
- Fill out and return the required paperwork to DHS to enroll their newborn in Medicaid

Hospitals may bill for newborn delivery and other newborn services separately from the claims for services they provide for the mother.

Billing Professional and Ancillary Claims

Newborns: Circumcision

All circumcisions performed on members more than 12 months after birth will require precertification from our Medical Management department and will be subject to a medical necessity review. Circumcision charges should be billed with appropriate CPT codes. Reimbursement is subject to change based on the Iowa Medicaid Fee Schedule.

HCPCS/CPT	Description
54150	Circumcision, using clamp or other device - newborn
54160	Circumcision, surgical excision other than clamp, device or dorsal split - newborn
54161	Circumcision, surgical excision other than clamp, device or dorsal split - except newborn

Billing Professional and Ancillary Claims

Sensitive Services

The following is a list of codes specific to sensitive health care services. Reimbursement is subject to change based on the Iowa Medicaid Fee Schedule:

HCPCS/CPT	Description
46608	Anoscopy; with removal of foreign body
57415	Removal of impacted vaginal foreign body (separate procedure) under anesthesia
59840	Dilation and curettage - used to induce a first trimester abortion, for termination of a pregnancy in the first 12 - 14 weeks of gestation
59841	Dilation and curettage - used to induce a second trimester abortion, for termination of a pregnancy after 12 - 14 weeks of gestation
99170	Anogenital examination with colposcopic magnification in childhood for suspected trauma

The following is a list of procedure codes, including other sensitive services for minors over the age of 12 and through the age of 18 (plus 364 days). Reimbursement is subject to change based on the Iowa Medicaid Fee Schedule:

HCPCS/CPT	Description
80100	Drug screen, qualitative; multiple drug classes chromatographic method, each procedure
80101	Drug screen, qualitative; single drug class method (for example, immunoassay, enzyme assay), each drug class
80102	Drug confirmation, each procedure
80103	Tissue preparation for drug analysis
80154	Benzodiazepines
80173	Haloperidol
80184	Phenobarbital
82055	Alcohol (ethanol); any specimen except breath
82075	Alcohol (ethanol); breath
82101	Alkaloids, urine, quantitative
82120	Amines, vaginal fluid, qualitative
82145	Amphetamine or methamphetamine
82205	Barbiturates, not elsewhere specified
82520	Cocaine or metabolite
82646	Dihydrocodeinone
82649	Dihydromorphinone
82654	Dimethadione
82742	Flurazepam
83840	Methadone
83992	Phencyclidine

Billing Professional and Ancillary Claims

Sterilization

Sterilization is any medical procedure, treatment or operation for the purpose of rendering an individual permanently incapable of reproducing. Sterilization does not include medical procedures that may have the effect of producing sterility but were performed for an entirely different purpose, such as removal of a cancerous uterus or prostate gland. To qualify for reimbursement, the following conditions must be met:

- 30 full days must elapse between the date of the consult and the date of surgery, but not more than 180 days
- Prior to sterilization, the provider must complete the "Consent for Sterilization" form (form 470-0835 or 470-0835S), available on the DHS website at **http://dhs.iowa.gov/ime/providers/forms.**

Please note: Payment cannot be made to providers of associated services, including hospitals, anesthesiologists, pathologists and radiologists, unless the consent form is completed in an accurate and timely manner. The state of Iowa DHS will ask for recoupment of fees from Amerigroup, which will subsequently be recouped from the provider.

The following are required before performing sterilization:

- Patient has voluntarily given his or her consent to be sterilized
- Patient was at least 21 years of age on the date of consent
- Patient is not mentally incompetent
- Patient is not institutionalized
- At least 30 days, but no more than 180 days, have elapsed between the date of consent and the sterilization
- Consent form used was the same form provided by DHS; no other form may be substituted
- Dates on the consent form cannot be altered

The following are the exceptions to the 30-day waiting period:

- Emergency abdominal surgery when the patient signs an informed consent at least 72 hours prior to surgery
- Premature labor when the patient has given informed consent at least 30 days prior to the expected date of confinement. The provider must indicate the expected date of confinement on the consent form

The provider must follow these sterilization procedures for Amerigroup to pay the claim:

- At the time of the sterilization consult, the nurse verifies the patient is a member of Amerigroup. The nurse then attaches the appropriate consent form to the front of the patient's chart.
- The patient completes, signs and dates the section titled Consent for Sterilization.
- If an interpreter is necessary, the interpreter signs the consent form.
- The provider completes, signs and dates the section titled Statement of Person Obtaining Consent. Include the name and address of the facility where the procedure will be performed.
- The scheduling nurse schedules surgery. If anything is not in order, the procedure is postponed until the issue is resolved.

- At the post-operative visit, the provider follows the instructions for use of alternative final paragraphs, signs and dates the Physician Statement, on the Sterilization Consent form.
- The provider forwards a copy of the signed Sterilization Consent form to the facility where the procedure was performed.
- The provider files the original, signed Sterilization Consent form in the member's chart.
- The provider sends a signed copy of the Sterilization Consent form to Amerigroup, either submitted with the claim or sent separately to the Claims department.

Billing Professional and Ancillary Claims

Hysterectomy

Payment will be made only for a medically necessary hysterectomy that is performed for a purpose other than sterilization and only when one or more of the following conditions are met:

- A member or her representative has signed an acknowledgment that she has been informed orally and in writing from the provider authorized to perform the hysterectomy that the hysterectomy will make the member permanently incapable of reproducing.

  This statement may be added to either the surgery consent form, written on the claim form, or on a separate sheet of paper. The member or her representative receiving the explanation must sign the statement.

  The following language is satisfactory for such a statement:

  "Before the surgery, I received a complete explanation of the effects of this surgery, including the fact that it will result in sterilization.

  (Date) (Signature of member or person acting on her behalf)"

  The vehicle for transmitting the acknowledgment that the member received the explanation before the surgery should not be the Consent for Sterilization, form 470-0835 or 470-0835S. This statement must be submitted to Amerigroup with the related Medicaid claim.

- The member was already sterile before the hysterectomy. The provider must certify in writing that the member was already sterile at the time of the hysterectomy and must state the cause of the sterility. The following language is satisfactory for such a statement:

  "**Before the surgery, this patient was sterile and the cause of that sterility was _____.**

  (Physician's signature) (Date)"

  This statement may be added to either the surgery consent form, written on the claim form, or a separate sheet of paper. A physician must sign any document stating the cause of sterility. This includes a history and physical, operative report, or claim form. This statement must be submitted to Amerigroup with the related Medicaid claim.

- The hysterectomy was performed as the result of a life-threatening emergency in which the physician determined that prior acknowledgment was not possible. The physician must include a description of the nature of the emergency.

If the physician certifies that the hysterectomy was performed for a life-threatening emergency and includes a description of the nature of the emergency, the claim will be reviewed on an individual basis. Payment will be permitted only in extreme emergencies.

Where the member is about to undergo abdominal exploratory surgery or a biopsy, and removal of the uterus could be a potential consequence of the surgery, the member should be informed of this possibility and given an opportunity to acknowledge in writing the receipt of this information.

This includes C-sections when there is a reasonable expectation a hysterectomy will be performed, such as in the event of an acreta.

Billing Professional and Ancillary Claims

Termination of Pregnancy

Abortions may only be authorized in the following situations:

- The pregnancy is the result of an act of rape or incest.
- A woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

The provider must complete a Certification Regarding Abortion form 470-0836 attesting to one of the circumstances listed above. In the case of rape or incest, the Provider must include evidence that the crime was reported to law enforcement authorities. The Certification Regarding Abortion form must be submitted to the Amerigroup Claims department, along with progress notes and any law enforcement documentation. Amerigroup will forward this information to Iowa's DHS for a final decision regarding coverage. After DHS has made its decision, Amerigroup will notify the provider's office of the decision.

Locate the Certification Regarding Abortion form on the Iowa DHS website at <<www.dhs.iowa.gov/ime/providers/forms>>. In the **Search DHS Forms Library** field, enter search criteria (e.g., "abortion certification") and click the **Search** button.

Please note: A termination of pregnancy must be scheduled and performed at an Iowa Medicaid-certified facility.

When a termination of pregnancy meets criteria for coverage, all other medically necessary services are covered as well. Complications arising from a termination of pregnancy, whether or not the termination of pregnancy is covered, are covered services.

Services incidental to a noncovered termination of pregnancy are not covered. Such services include, but are not limited to, any of the following when directly-related to a noncovered termination of pregnancy:

- Interpretation Services
- Laboratory Testing
- Recovery Room Services
- Routine Follow-Up Visits
- Transportation (prenatal visits are covered)

- Ultrasound Services

Billing Professional and Ancillary Claims
Billing Members for Services Not Medically Necessary

Providers may bill an Amerigroup member for a service that is not medically necessary if all of the following conditions are met:

- The member requests a specific service or item that, in your opinion, may not be reasonable or medically necessary.
- The member requests a specific service or item that, in Amerigroup's opinion, may not be reasonable or medically necessary.
- The provider obtains a written acknowledgement verifying that you notified the Amerigroup member of financial responsibility for services rendered.
- The member signs and dates the acknowledgement, indicating that the member has been notified of their responsibility to pay for the requested service prior to services being rendered.

Billing Professional and Ancillary Claims
Recommended Fields for CMS-1500

All professional providers and vendors should bill Amerigroup using the most current version of the CMS-1500 claim form. Please review the Electronic Data Interchange (EDI) Companion guide for assistance at **providers.amerigroup.com/Pages/edi.aspx**.

CHAPTER 12: BILLING INSTITUTIONAL CLAIMS

Provider Services: **<<1-800-454-3730>>**
Provider Services Fax: **<<1-800-964-3627>>**
Hours of Operation: **Monday to Friday, 7:30 a.m.-6 p.m. Central time**

Billing Institutional Claims
Overview

Billing for hospitals and other health care facilities and services can require special attention because major services have their own set of billing requirements. Throughout this chapter, specific billing requirements are broken down into the following service areas:

- Emergency room visits
- Urgent care visits
- Maternity
- Termination of pregnancy
- Inpatient acute care
- Inpatient sub-acute care
- Outpatient laboratory, radiology and diagnostic services
- Outpatient surgical services
- Outpatient infusion therapy visits and pharmaceuticals

We also have included helpful billing guidelines for the ancillary services used most often by providers, including diagnostic imaging. These ancillary services include the following:

- Ambulance services
- Ambulatory surgical centers
- Physical, speech and occupational therapy
- Durable medical equipment
- Dialysis
- Home infusion therapy
- Laboratory and diagnostic imaging
- Skilled nursing facilities
- Home health care
- Hospice

Please note: A member's benefits may not cover some of these services; confirm coverage before providing service.

And finally, this chapter will take a look at specific coding guidelines for the CMS-1450 (UB-04) claim form for hospital and health care facilities.

Billing Institutional Claims
Basic Billing Guidelines

In general, the basic billing guidelines for institutional claims submitted to Amerigroup are:

- Use Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) codes or revenue codes. Valid HCPCS, CPT or revenue codes are required for all line items billed, whether sent on paper or electronically.

- Provide medical records. Medical records for certain procedures may be requested for determination of medical necessity.
- Use modifiers in accordance with your specific billing instructions.
- Use codes for unlisted procedures. Because some provider services or procedures are not found in CPT, specific code numbers for reporting unlisted procedures have been designated. When using an unlisted procedure code, include a description of the service to help us calculate the appropriate reimbursement. We may request the member's medical records.
- Complete the appropriate billing for supplies and materials. Do not use CPT code 99070, which is for supplies and materials provided over and above those usually included with an office visit or other services. Amerigroup does not accept CPT code 99070. Health care providers must use HCPCS Level II codes, which provide a detailed description of the service.

Please Note: System edits are in place for both electronic and paper claims. Claims submitted improperly cannot be processed easily and most likely will be returned.

Billing Institutional Claims

Emergency Room Visits

The billing requirements for an emergency room visit apply to the initial treatment of a medical or psychiatric emergency, but only if the patient does not remain overnight. If the emergency room visit results in an admission, all services provided in the emergency room must be billed in conformity with the guidelines and requirements for inpatient acute care.

The billing requirements for emergency room treatment cover all diagnostic and therapeutic services, including, but not limited to:

- Equipment
- Facility use, including nursing care
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the emergency room visit

Precertification is not required for medically necessary emergency services.

Specific coding is required for emergency room billing. Use the following guidelines, including:

- Bill each service date as a separate line item.
- Perform a screening examination on the member, regardless of copay.
- Use CPT codes 99284 or 99285 for emergency room billing.
- Use ICD principal diagnosis codes, as required, for all services provided in an emergency room setting.
- Use revenue codes 0450-0452 and 0459, as required.

Please note: Unless clinically required, follow-up care should never occur in the emergency department. Members should be referred back to their PCP and correct billing should follow standard, nonemergency guidelines.

Billing Institutional Claims
Urgent Care Visits

The billing requirements for urgent care visits apply to all urgent care cases treated and discharged from the hospital outpatient department or emergency room.

> **Urgent care:** Nonscheduled, nonemergency hospital services required to prevent serious deterioration of a patient's health as a result of an unforeseen illness or injury.

Urgent care billing should detail all diagnostic and therapeutic services, including, but not limited to:

- Equipment
- Facility use, including nursing care
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the visit

Specific coding is required for urgent care billing. Use the following guidelines, including:

- Bill each service date as a separate line item.
- Use current ICD principal diagnosis codes, as required, for all services provided in an urgent care setting or designated facility.
- Use the required CPT codes 99281-83.
- Use the required revenue codes 045X, 0516, 0526, 0700, 072X.

Please note: Urgent care billing does not apply when the member is admitted and treated for inpatient care following urgent care treatment. If the member is admitted following urgent care, the billing shifts to acute or sub-acute care.

Billing Institutional Claims
Maternity Services

The billing requirements for maternity care apply to all live and stillbirth deliveries. Payment for services includes, but is not limited to, the following:

- Room and board for mother, including nursing care
- Nursery for baby, including nursing care
- Delivery room/surgical suites
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Other services incidental to admission

The maternity care rate covers the entire admission. If an admission is approved for extension beyond the contracted time limit for continuous inpatient days, the billing requirement for the entire admission shifts to inpatient acute care. This applies to each approved and medically necessary service day. Therapeutic termination of pregnancy, treatment for ectopic and molar pregnancies and similar conditions are excluded from payment under this rate.

Billing Institutional Claims
Termination of Pregnancy

Reimbursement for termination of pregnancy may only be authorized in the following situations:

- If the pregnancy is the result of an act of rape or incest.
- In the case where a woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

The provider must complete and submit a Certification Regarding Abortion form 470-0836 attesting to one of the circumstances listed above. In the case of rape or incest, the provider must include evidence that the crime was reported to law enforcement authorities. The Certification Regarding Abortion form 470-0836 (Rev. 7/11) must be submitted to the Amerigroup Claims department, along with progress notes and any law enforcement documentation. Amerigroup will forward this information to Iowa's DHS for a final decision regarding coverage. After DHS has made its decision, Amerigroup will notify the provider's office of the decision.

Locate the Certification Regarding Abortion form on the Iowa DHS website at **www.dhs.iowa.gov/ime/providers/forms**. In the **Search DHS Forms Library** field, enter search criteria (e.g., "abortion certification") and click the **Search** button. **Please note:** Failure to submit the Certification Regarding Abortion form correctly will result in denial of the claim.

Billing Institutional Claims
Inpatient Acute Care

The billing requirements for inpatient acute care apply to each approved and medically necessary service day in a licensed bed. These requirements include, but are not limited to:

- Room and board, including nursing care
- Emergency room, if connected to admission
- Urgent care, if connected to admission
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Surgical and recovery suites
- Other services incidental to the admission

Please note: Precertification is required for all admissions except standard vaginal delivery and Cesarean sections.

Special billing instructions and requirements:

- Medical Management approval is required for all admissions except routine deliveries.
- Observation room, or outpatient billing with an inpatient stay, should be completed on the CMS 1450 claim form. Complete the "From" box of Form Locator 6 (FL 6) and Form Locator 17 (FL 17) correctly to ensure the claim is processed. Note the following requirements:
  - Ensure the dates reported in (FL 6) and (FL 17) are the same

- Verify the charges in (FL 6) and (FL 17) reflect the date the patient was admitted to the hospital
- Do not use (FL 6) and (FL 17) to include the date of any observation stay or outpatient charges that occurred prior to inpatient admission. This usage is incorrect and may cause processing delays.

Billing Institutional Claims
Inpatient Sub-Acute Care

The billing requirements for inpatient sub-acute care include each approved and medically necessary service day in a licensed and accredited facility at the appropriate level of care.

> **Sub-acute care:** Includes levels of inpatient care less intensive than those required in an inpatient acute care setting.

Covered services include, but are not limited to:

- Room and board, including nursing care
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the admission

Please note: All sub-acute admissions require precertification and a treatment plan.

The treatment plan must accompany the admission and include:

- Functional, reasonable, objective and measurable goals within a predictable time frame for each skilled discipline
- A discharge plan and customized options, identified and implemented from the admission date
- Weekly summaries for each discipline
- Biweekly conference reports

Billing Institutional Claims
Outpatient Laboratory, Radiology and Diagnostic Services

Specific billing requirements for services related to outpatient laboratory, pathology, radiology and other diagnostic tests include, but are not limited to:

- Facility use
- Nursing care, including incremental nursing
- Equipment
- Professional services
- Specified supplies and all other services incidental to the outpatient visit

Please note: Outpatient radiation therapy is excluded from this service category and should be billed under the requirements of the Other Services category.

Billing Institutional Claims
Outpatient Surgical Services

Specific billing requirements related to outpatient surgical services include, but are not limited to:

- Facility use, including nursing care
- Blood
- Equipment
- Imaging services
- Implantable prostheses
- Laboratory
- Pharmaceutical
- Radiology
- Supplies
- All other services incidental to the outpatient surgery visit

Please Note: Even if a service is classified by the hospital as an outpatient service, if the member is receiving that service as of 12 a.m., bill the service at the inpatient diagnostic related group (DRG) rate.

Specific dates, codes and medical records may be required for billing. Use the following guidelines:

- Follow the billing requirements for outpatient surgery when the respiratory therapy department performs an ECG, EEG or EKG. Do not apply the outpatient therapy billing requirements.
- Include service dates for each procedure (both principal and other).
- Include CPT/HCPCS codes for each surgical procedure in form locators 44 (HCPCS/RATES).
- Provide medical records when Amerigroup needs to review and determine the correct grouping for services not defined in the surgery grouping.
- Use billing field entry 13X.
- Use revenue codes 036X, 0480, 0481, 0490, 070X, 071X, 075X, 076X, 079X and 0975, as required, along with the appropriate CPT/HCPCS code.
- Use the CPT/HCPCS code, as mandated by the HIPAA, for outpatient surgery billing.

Billing Institutional Claims
Outpatient Infusion Therapies and Pharmaceuticals

This section covers the following topics:

- Outpatient infusion therapies
- Outpatient infusion pharmaceuticals

Outpatient Infusion Therapies

Billing requirements for outpatient infusion therapy visits apply to each outpatient hospital visit and include, but are not limited to:

- Facility use, including nursing care
- Equipment
- Intravenous solutions, excluding pharmaceuticals
- Kinetic dosing
- Laboratory

- Professional services
- Radiology
- Supplies, including syringes, tubing, line insertion kits, etc.
- Other services incidental to the outpatient infusion therapy visit

Outpatient Infusion Pharmaceuticals

Special billing requirements for outpatient infusion pharmaceuticals apply to drugs such as chemotherapy, hydration and antibiotics used during each outpatient infusion therapy visit. An important exception is for blood and blood products, which are billed under the Other Services category. Special outpatient infusion pharmaceuticals billing instructions are listed below.

Specific codes and service dates are required, including:

- Use revenue codes 026X, 028X, 0331, 0335 or 0940, as required, for each outpatient infusion therapy visit.
- Use revenue code 0940 or 0949 with CPT/HCPCS codes 36511-36513, 36515-36516 or 36522 when billing for therapeutic aphaeresis claims.
- List each drug for each visit as a separate line item and include the service date.
- Use HCPCS codes, as required, for all pharmaceuticals when:
  - Billed with revenue codes 0250-0252, 0256-0259, or 063X. Include the units with pharmaceutical CPT/HCPCS codes
  - Billed with revenue codes 026X, 028X, 0331, 0335, 0940
- When using an unlisted CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CMS-1450 claim form.

Billing Institutional Claims
Ancillary Billing Overview

Most ancillary claims are submitted for laboratory and diagnostic imaging or durable medical equipment (DME). The following sections provide special billing requirements for each.

Please note: Because the member's benefits may not cover all of the services listed, confirm benefit coverage first.

Billing Institutional Claims
Ambulance Services

Ambulance providers, including municipalities, should use the CMS-1500 form to bill for ambulance services. Use the appropriate two-digit origin and destination codes that describe the "to" and "from" locations.

Billing Institutional Claims
Ambulatory Surgical Centers

Most outpatient surgery delivered in an ambulatory surgery center requires precertification. Ambulatory Surgical Centers bill on the CMS-1500 form.

Billing Institutional Claims
Physical, Speech and Occupational Therapies

The physical, speech or occupational therapy setting determines the correct billing form:

- CMS-1500 claim form: When providing services in an office, clinic or outpatient setting
- CMS-1450 claim form: When providing services in a rehabilitation center or for physical, speech, or occupational therapists affiliated with home health agencies, providing services in a patient's home

Please note: The treatment is limited to 60 visits per therapy discipline per enrollment year. All physical, speech or occupational therapy for members in a Birth to Three program requires precertification. Contact the Amerigroup Medical Management department: <<1-800-454-3730>>.

Billing Institutional Claims
Durable Medical Equipment

Billing for custom-made durable medical equipment (DME), prescribed to preserve bodily functions or prevent disability, requires preservice review. Without such review, claims for DME will be denied. Prior to dispensing, please contact Amerigroup's Medical Management department at <<1-800-454-3730>>.

Please note: The presence of an HCPCS code does not necessarily mean that the benefit is covered or that payment will be made. Some DME codes may be By Report (customized) and therefore require additional information for preservice review and processing.

DME billing requires a differentiation between rentals and purchased equipment, as well as specific codes and modifiers. Special guidelines for DME billing:

- Use HCPCS codes for DME or supplies.
- Use an unlisted or miscellaneous code, such as E1399, when a HCPCS code does not exist for a particular item of equipment.
- Use valid codes for DME and supplies. If valid HCPCS codes exist, unlisted codes will not be accepted.
- Attach the manufacturer's invoice to the claim if using a miscellaneous or unlisted code. The invoice must be from the manufacturer, not the office making the purchase.

Please note: Catalogue pages are not acceptable as a manufacturer's invoice.

Billing Institutional Claims
Durable Medical Equipment: Rentals

Most DME is dispensed on a rental basis and requires medical documentation from the prescribing provider. Rented items remain the property of the DME provider until the purchase price is reached. Charges for rentals exceeding the reasonable charge for a purchase are not accepted. Rental extensions may be obtained only on approved items.

Please note: DME providers should use normal equipment collection guidelines. Amerigroup is not responsible for equipment not returned by members.

Billing Institutional Claims
Durable Medical Equipment: Purchase

DME may be reimbursed on a rent-to-own basis, unless otherwise specified at the time of review by our Medical Management department.

Billing Institutional Claims
Durable Medical Equipment: Wheelchairs and Wheeled Mobility Aids

At Amerigroup, we follow Medicaid guidelines for calculating By Report (customized) wheelchair claims. Claims must include the following:

- Catalogue number
- Item description
- Manufacturer's name
- Model number

Mark each catalogue page or invoice line so we can match each item to the appropriate claim line. Enter the total MSRP of the wheelchair in the Reserved for Local Use field (Box 19) on the CMS-1500 claim form. The total MSRP includes:

- Accessories
- Modifications or replacement parts

Also provide the name of the Rehabilitation and Assistive Technology of America (RESNA)-certified technician.

Billing Institutional Claims
Dialysis

Dialysis centers and other entities performing dialysis should use the CMS-1450 claim form to bill for dialysis services. You must obtain precertification for all dialysis care, except where Medicare is the primary payer. Contact Amerigroup's Medical Management department for precertification: <<1-800-454-3730>>.

Billing Institutional Claims
Home Infusion Therapy

Home infusion therapy requires precertification. When billing for home infusion therapy, use the CMS-1500 form and follow these guidelines:

- Obtain precertification, as required, from Amerigroup's Medical Management department for all infusion therapy.
- Submit all claims within the contracted filing limit.
- Use the appropriate HCPCS codes to bill for all injections.
- Use HCPCS code J3490 along with the National Drug Code (NDC) for billing injections only if an appropriate injection code is not found.

Billing Institutional Claims
Laboratory and Diagnostic Imaging

For laboratory and diagnostic imaging, use the CMS-1500 form and refer to the basic billing guidelines found in the **Overview** section of this chapter.

Billing Institutional Claims
Skilled Nursing Facilities

All skilled nursing facility care requires precertification. Contact Amerigroup's Medical Management department for precertification and bill using the CMS-1450 form. Amerigroup's Medical Management department phone: <<1-800-454-3730>>.

Billing Institutional Claims
Home Health Care

All home health care requires precertification from Amerigroup's Medical Management department before delivery of service. When billing for a home health care visit, use the CMS-1450 form.

Please Note: When billing for supplies and equipment used in a home health care visit, please refer to the **Durable Medical Equipment** section of this chapter for billing requirements.

Amerigroup's Medical Management department phone is <<1-800-454-3730>>.

Billing Institutional Claims
Hospice

Hospice services require precertification. Contact Amerigroup's Medical Management department for precertification before hospice admission. When billing for hospice services, use the CMS-1450 form. For information regarding billing, member qualification and coverage information, please call Amerigroup's Medical Management department at <<1-800-454-3730>>.

Billing Institutional Claims
Additional Billing Resources

The following reference books provide detailed instructions on uniform billing requirements:

- CPT, published by the American Medical Association (AMA)
- HCPCS, National Level II (current year), published by the Centers for Medicare & Medicaid Services (CMS)
- ICD (current edition) Volumes 1,2,3 (current year), published by the Practice Management Information Corporation

Billing Institutional Claims
CMS-1450 Claim Form

All Medicare-approved facilities should bill Amerigroup using the most up-to-date version of the CMS-1450 claim form. All fields must be completed using standardized code sets. These code sets are used to ensure that claims are processed in an orderly and consistent manner. HCPCS provides codes for a variety of services and consists of Level I and Level II codes:

- Level I: CPT codes determined by the AMA and represented by five numeric digits.
- Level II: Other codes identifying products, supplies and services not included in the CPT codes, such as ambulance services and DME. Sometimes referred to as the alphanumeric codes because they consist of a single alphabetical letter followed by four numeric digits.

In some cases, two-digit/character modifier codes should accompany the Level I or Level II coding.

Billing Institutional Claims
CMS-1450 Revenue Codes

CMS-1450 revenue codes are required for all institutional claims.

Billing Institutional Claims
Institutional Inpatient Coding

For institutional inpatient coding, use the guidelines in the following code manuals:

- Use current ICD applicable and procedure codes in Boxes 74-74e of the CMS-1450 claim form when the claim indicates that a procedure was performed.
- Use modifier codes when appropriate; refer to the current edition of the Provider's CPT manual published by the AMA.
- Refer to your Provider Agreement for diagnostic related group (DRG) information.

Billing Institutional Claims
Institutional Outpatient Coding

For institutional outpatient coding, use the guidelines in the following code manuals:

- The Current Procedural Terminology manual published by the AMA.
- The Healthcare Common Procedure Coding System published by the Centers for Medicare & Medicaid Services (CMS).

Please note: When using an unlisted CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CMS-1450 claim form.

Billing Institutional Claims
Recommended Fields for CMS-1450

For assistance in completing the CMS-1450 form, please review the Electronic Data Interchange (EDI) Companion guides at **providers.amerigroup.com/Pages/edi.aspx**.

CHAPTER 13: MEMBER TRANSFERS AND DISENROLLMENT

Provider Services:	**<<1-800-454-3730>>**
Provider Services Fax:	**<<1-800-964-3627>>**
Hours of Operation:	**Monday to Friday, 7:30 a.m.-6 p.m. Central time**
Member Services:	**<<1-800-600-4441>>**
	<<711>> (TTY)
Hours of Operation:	**Monday to Friday, 7:30 a.m.-6 p.m. Central time**

Member Transfers and Disenrollment

Overview

At Amerigroup, our members have the freedom to choose their most important link to quality health care: their doctor. After enrollment, we strongly encourage our members to select a PCP and remain with that provider because we believe in the positive impact of having a medical "home". This home establishes a centralized hub from which all health care can be coordinated, no matter how many other caregivers become involved.

Occasionally, members may encounter barriers to effective relationships with their PCP. These obstacles may arise from geographical access, cultural and language differences, or simply personal preferences. Our members may change their PCP at any time, for any reason.

Members also have the right to change health care plans, following specific rules and timelines. If a member requests disenrollment, Amerigroup will provide information and assistance in the disenrollment process.

We are committed to supporting providers' practices as well. Providers have the right to request that a member be reassigned to another PCP, under certain conditions and following specific guidelines.

Amerigroup notifies PCPs of changes in member assignments through PCP Assignment Reports. These reports are available on Availity, our secure provider portal on the **Providers** page of our website at providers.amerigroup.com/ia. Click on **Login** or **Register** to access the site. Providers also may call Provider Services at <<1-800-454-3730>>.

Member Transfers and Disenrollment

PCP-Initiated Member Transfers

A PCP may request member reassignment to a different PCP by completing and submitting the Provider Request for Member Deletion from PCP Assignment form located on the **Providers** page of our website at providers.amerigroup.com/ia. To access this form, just select **Medical** > **Forms**.

Amerigroup will conduct a thorough review of the request for reassignment to determine whether the cause and documentation are sufficient to approve the request. This review includes monitoring to ensure consistency with our guidelines and policies.

The provider is expected to coordinate service for up to 30 days after the date Amerigroup receives the change request form. Upon completing the PCP assignment change, we will forward the form and any other information related to the case to the Member Services representative. This representative informs the member of the change within 5 working days. The change will be effective the day Amerigroup enters the change into the system.

Member Transfers and Disenrollment
PCP-Initiated Member Disenrollment

The disenrollment process for abusive behavior and failure to follow a prescribed treatment plan is as follows:

- Complete the Provider Request for Member Deletion from PCP Assignment form located on the **Providers** page of our website at **providers.amerigroup.com**/ia, through **Medical** > **Forms**.
- Mail or fax (preferred) the form to:

  Amerigroup Iowa, Inc.
  P.O. Box 62429
  Virginia Beach, VA 23466-2429
  Fax: <1-800-964-3627>
- Continue to manage the member's care, as required, until we can reassign the member to another PCP, or not more than 30 days from the day we receive the Provider Request for Member Deletion from PCP Assignment form, whichever comes first.

Following Amerigroup's receipt of the Provider Request for Member Deletion from PCP Assignment form, the process is to:

- Scan and log the form into the system for tracking purposes.
- Reassign the member to a new PCP for continuity of care. The effective date is no later than 30 days from the date on the Provider Request for Member Deletion from PCP Assignment form.
- Log the new PCP assignment into the tracking system.
- Send an identification (ID) card and fulfillment material to the member indicating the newly assigned PCP's name, address and phone number.
- Document any abusive behavior and notify the Amerigroup Fraud and Abuse department if the abusive behavior continues.
- Send a warning letter to the member stating that if the behavior continues, Amerigroup will file a disenrollment request with Iowa's Department of Human Services (DHS). If DHS grants approval, Amerigroup proceeds with the disenrollment process.

Prior to disenrollment, we will make every attempt to resolve issues and keep the member in our health care plan. If these attempts fail, we will reassign the member to another PCP or forward the disenrollment request form to the appropriate state agency requesting member reassignment to another health care plan.

Member Transfers and Disenrollment
State Agency-Initiated Member Disenrollment

Contracted state agencies inform Amerigroup of membership changes by sending daily and monthly enrollment reports. These reports contain all active membership data and incremental changes to eligibility records and Amerigroup disenrolls members not listed on the report.

Member Transfers and Disenrollment
Member-Initiated PCP Reassignment

Members have the right to change their PCP at any time. When a member enrolls in Amerigroup, he or she may select a PCP or allow their PCP to be assigned. After that, if the member wants to make a change, he or she is instructed to call our Member Services to request an alternate PCP.

Amerigroup accommodates member requests for PCP reassignment whenever possible. Our staff will work with the member to make the new selection, focusing on special needs. Our policy is to maintain continued access to care and continuity of care during the transfer process.

When a member calls to request a PCP change:

- The Member Services representative checks the availability of the member's choice. If the member can be assigned to the selected PCP, the Member Services representative will do so. If the PCP is not available, the representative will assist the member in finding an available PCP. If the member advises the representative that he or she is hospitalized, the PCP change will take effect upon discharge.
- Amerigroup notifies PCPs of member transfers through the PCP Assignment Report. These reports are available on Availity, our secure provider portal on the **Providers** page of our website at **providers.amerigroup.com**/ia. Click on **Login** or **Register** and register or log on to access the site.
- The effective date of a PCP change will be the same as the date of the member request.

Member Transfers and Disenrollment

Member-Initiated Disenrollment Process

When members enroll in our program, we provide instructions on disenrollment procedures. Disenrollments become effective the last day of the calendar month following administrative cut-off or are subject to the Iowa DHS cut-off dates.

If a member asks a provider how to disenroll from Amerigroup, the provider should direct the member to call Member Services at <<1-800-600-4441>> (TTY 711).

Please note: Providers may not take retaliatory action against any member for requesting transfer or disenrollment.

When Amerigroup's Member Services receives a call from a member who wants to disenroll, we attempt to find out the reason for the request and determine if we can resolve the situation. If we cannot resolve the situation, we inform the member that the disenrollment process will take 15 to 45 days and refer the member to the Iowa DHS.

Member Transfers and Disenrollment

Member Transfers to Other Plans

Members may choose a different health care plan on an annual basis during the open enrollment period. As required by federal regulations, the open enrollment period lasts for 90 days for IA Health Link members. Upon initial enrollment, a member has 90 days to switch plans and once a year there after, they will have an opportunity to switch plans.

However, members retain the right to change their health care plan when they have "just cause", which can be any of the following:

- A lack of access to necessary services covered under the health care plan's contract
- A lack of access to providers experienced in dealing with the member's health care needs
- The health care plan does not, for moral or religious objections, cover the services the member seeks
- The member has concerns over quality of care
- The member requires related services to be performed at the same time and not all related services are available within the health care plan's network

- The member's PCP leaves the health care plan and participates with another health care plan under contract with the state of Iowa. The member requests the transfer to remain with the PCP

The member, Amerigroup or the Iowa DHS may initiate member disenrollment. If the request comes from a member and includes a member grievance, the grievance will be processed separately through the grievance process. Disenrollment may result in the following:

- Enrollment with another health care plan
- Termination of eligibility
- Return to traditional Medicaid for continuity of care if the member's benefits fall into a voluntary aid code

Member Transfers and Disenrollment

Amerigroup -Initiated Member Disenrollment

Amerigroup also may request disenrollment for a member who has moved permanently out of the state. When a member moves out of our service area, he or she is responsible for notifying DHS of the new permanent address. Iowa's DHS will disenroll the member from Amerigroup.

There are a number of situations where Amerigroup can request disenrollment. They are:

- Just cause
- COP/CIP Community-Based waiver or Family Care
- Infants with low birth weight (under 1200 grams)
- Inmates of a public institution
- Commercial HMO
- Death

CHAPTER 14: GRIEVANCES AND APPEALS

Provider Services:	**<<1-800-454-3730>>**
Provider Services Fax:	**<1-800-964-3627>>**
Hours of Operation:	**Monday to Friday, 7:30 a.m.-6 p.m. Central time**
Member Services:	**<<1-800-600-4441>>**
	<<711>> (TTY)

Grievances and Appeals

Overview

We encourage providers and members to seek resolution of issues through our grievances and appeals process. Verbal complaints and written grievances are tracked and trended, resolved within established time frames and referred to peer review when needed. The Amerigroup grievances and appeals process meets all state of Iowa requirements and federal laws. The building blocks of this resolution process are the grievance and the appeal:

> **Grievance:** Any expression of dissatisfaction about any matter other than an "action" from a provider or member to Amerigroup.
>
> **Appeal:** A formal request for review of an action by the member or the member's authorized representative for Amerigroup to reconsider and review a decision made by Amerigroup

Provider grievances and appeals are classified into the following categories:

- Grievances relating to the operation of Amerigroup , including:
  - Benefit interpretation
  - Claim processing
  - Reimbursement
- Provider appeals related to adverse determinations
- Provider appeals of nonmedical necessity claims determinations

If a member has a grievance, we would like to hear about the issue, either by phone or in writing. Members have the right to file a grievance regarding any aspect of Amerigroup's services. Member grievances and appeals include, but are not limited to, the following:

- Access to health care services
- Care and treatment by a provider
- Issues having to do with how we conduct business

Amerigroup does not discriminate against providers for filing a grievance or an appeal. Providers are prohibited from penalizing a member in any way for expressing a complaint or filing a grievance.

Please note: Amerigroup offers an expedited appeal for decisions involving urgently needed care. Standard and expedited appeals are never reviewed by a person who is subordinate to the initial decision-maker.

Grievances and Appeals

Providers: Grievances Relating to the Operation of the Plan

A provider may be dissatisfied or concerned about another provider, a member or an operational issue, including claims processing and reimbursement. Provider grievances must be submitted in writing and include the following:

- Provider's name
- Date of the incident
- Description of the incident

Submit the grievance to the following address:

Amerigroup Iowa, Inc.
4800 Westown Parkway, Suite 100
West Des Moines, IA 50309

Providers may also fax grievances to <<FAX NUMBER>>.

A grievance may be filed up to 60 days from the date the provider became aware of the issue. Appeals may be filed up to 30 days from the date on the Notice of Action letter advising of an adverse determination.

Amerigroup may request medical records or an explanation of the issues raised in the grievance in the following ways:

- Phone
- Fax, with a signed and dated letter
- Mail, with a signed and dated letter

The timelines for responding to the request for more information are as follows:

- Grievances or appeals: Providers must comply with the request for additional information within 10 days of the date on the request.
- Expedited appeals: Providers must comply with the request for additional information within 24 hours of the date on the request.

Providers are notified in writing of the grievance resolution, including their right of appeal, if any. Findings or decisions of peer review or quality of care issues are not disclosed.

Grievances and Appeals

Providers: When to Expect Resolution for a Grievance or Appeal

- Provider grievances: Amerigroup will investigate and resolve provider grievances within 90 business days of receipt of the grievance.
    - Expedited grievances: Amerigroup will investigate and respond within three business days of receipt to resolve expedited grievances.
- Provider appeals: Amerigroup sends a written resolution letter to the Provider within 45 business days of the receipt of the appeal. The letter also provides details on further rights to appeal.
- Expedited appeals: Amerigroup will investigate and respond within 72 hours of receipt to resolve expedited appeals.

Grievances and Appeals

Providers: Appeals Related to Adverse Determinations

When a provider expresses dissatisfaction about an adverse determination involving a clinical issue, the case is handled automatically as an appeal or reconsideration rather than a complaint.

> **Adverse determination:** A denial, modification or reduction of services based on eligibility, benefit coverage or medical necessity.

Claims denials also are considered adverse determinations. If a provider wants to challenge a claims decision, the provider may begin a claim payment appeal.

> **Claim payment appeal:** The process by which a provider may challenge the disposition of a claim that has already been decided.

Requests for claim payment appeals must be made in writing to IA Health Link within 60 days of a claim disposition and must include all pertinent information. The appeal should be mailed to:

> Claim Appeals/Correspondence
> Amerigroup Iowa, Inc.
> P.O. Box 61599
> Virginia Beach, VA 23466-1599

Claim payment appeal requests are resolved within 30 days of receipt of the written request in one of the following ways:

- Amerigroup changes a previous claim disposition: The provider will be notified of the final disposition through a remittance advice (RA) notice indicating the additional payment due to the provider.
- Amerigroup upholds a previous claim disposition: The provider will receive a resolution letter with the details of the decision.

Grievances and Appeals

Providers: Appeals Related to Non-Medical Necessity Claims Determinations

Claim payment appeals also may include retrospective medical necessity reviews. Requests for this kind of review must be submitted with all pertinent information, within 365 days of a claim disposition and be submitted in writing to Amerigroup to:

> Claim Appeals/Correspondence
> Amerigroup Iowa, Inc.
> P.O. Box 61599
> Virginia Beach, VA 23466-1599

Claim payment appeal requests are resolved within 30 days of receipt of the written request in one of the following ways:

- Amerigroup changes a previous claim disposition: The provider will be notified of the final disposition through an RA notice indicating the additional payment due to the provider.
- Amerigroup upholds a previous claim disposition: The provider will receive a resolution letter with the details of the decision.

Grievances and Appeals
Providers: Mediation and Arbitration

If the provider is not satisfied with the outcome of a review conducted through the provider appeal process, additional steps may be taken as stated in the Provider Agreement:

- Mediation
- Arbitration

If these processes have been exhausted, the provider may file a complaint with the Department of Human Services:

IA Department of Human Services
Appeals Department
305 E. Walnut Street
Des Moines, IA 50319

Grievances and Appeals
Members: Filing a Grievance

To help ensure that Amerigroup members' rights are protected, all members are entitled to a grievances and appeals process. Our goal is to resolve verbal and written grievances in a timely manner and in accordance with state and federal regulations. Members are encouraged to discuss their concerns with Amerigroup's Member Services department, who can help the member submit a grievance. The representative interviews the member and records details in the Member Services tracking system.

The member may file a grievance verbally with our Member Services department or they can submit a written grievance with as much information as possible, including:

- Who is part of the grievance
- What happened
- When the incident happened
- Where the incident happened
- Why the member was not happy with the health care services

The member must attach documents that will help us investigate the problem and should mail the written grievance to the Amerigroup Grievances and Appeals department at:

Amerigroup Iowa, Inc.
Appeals Processing
4800 Westown Parkway, Suite 100
West Des Moines, IA 50309

- The Grievance department may request medical records or an explanation from the provider(s) involved in the case.
- The Grievance department notifies providers of the need for additional information either by phone, mail or fax. Written correspondence to providers includes a signed and dated letter.
- Providers are expected to respond to requests for additional information within 10 days.
- If the Grievance department is unable to resolve the grievance within the 30 day period, we will notify the member in writing and will explain the reason for the delay. This may extend the case up to an additional 14 days for members. If the timeframe is extended, for any extension not requested by the

member, Amerigroup will give the member written notice of the reason for the delay. There is no right to appeal a grievance decision

Interpreter services and translation of materials into non-English languages and alternative formats are available to support members with the grievance and appeals process, at no cost.

Grievances and Appeals
Members: Resolution

Amerigroup investigates the member's grievance to develop a resolution. After we make a determination, we send a resolution letter to the member outlining our findings.

Grievances and Appeals
Members: Appeals

If a Member would like to file an appeal regarding how we solved their problem, he or she must notify us within 90 calendar days of the date on the Notice of Action letter. The request for an appeal may be verbal or written. Verbal appeals must be followed-up with in writing. Providers may submit appeals on a member's behalf with written consent. Appeals are divided into the following categories: Standard appeal and expedited appeal.

****Standard Appeal:** The appropriate process when a Member or his or her representative requests that Amerigroup reconsider the denial of a service or payment for services, in whole or in part. Iowa's standard appeal process requires resolution within 45 calendar days of receipt of the written Appeal request.

****Expedited Appeals:** An appeal when the amount of time necessary to complete a standard appeal process could jeopardize the Member's life, health or the ability to maintain or regain maximum function. Iowa's expedited appeal process requires resolution in 72 hours of receipt of the Expedited Appeal request, or within 14 calendar working days if the enrollee requests extension or if Amerigroup and DHS determine it's in the best interest of the enrollee to extend the decision timeframe

Members have the right to appeal Amerigroup's denial of services or payment for services, in whole or in part. A denial of this type is called an action. A Member or his or her representative may submit a verbal or written appeal regarding an action within 90 calendar days from receipt of the denial letter. With the exception of expedited appeals, all verbal appeals must be confirmed in writing and signed by the Member or his or her representative.

Grievances and Appeals
Members: Response to Standard Appeals

After Amerigroup receives a verbal or written appeal request, the Grievances and Appeals department takes the issue into consideration and investigates the case. The member, his or her representative and the provider are given the opportunity to submit written comments and documentation relevant to the appeal. Amerigroup may request medical records or a provider explanation of the issues raised in the appeal by:

- Phone
- Fax, with a signed and dated letter
- Mail, with a signed and dated letter

Providers are expected to comply with the request for additional information within 10 days.

When the appeal is the result of a medical necessity determination, a physician reviewer of the same or similar specialty who was not involved in the initial decision, and has experience treating the condition being appealed, reviews the case. The physician reviewer contacts the provider, if needed, to discuss possible alternatives.

Grievances and Appeals
Members: Resolution of Standard Appeals

Standard appeals are resolved within 45 calendar days of receipt of the initial written or verbal request. Members are notified in writing of the appeal resolution, including their right to further appeal, if any.

Grievances and Appeals
Members: Extensions

The resolution time frame for an appeal not related to an ongoing hospitalization or emergency may be extended up to 14 calendar days if:

- The member or his or her representative requests an extension
- Amerigroup shows that there is a need for additional information and that the delay is in the member's interest

Grievances and Appeals
Members: Expedited

If the amount of time necessary to participate in a standard appeal process could jeopardize the member's life, health or ability to attain, maintain or regain maximum function, the member may request an expedited appeal. Amerigroup will inform the member of the limited time frame available for providing information, as well as that the duration for submitting an expedited appeal is limited.

Grievances and Appeals
Members: Timeline for Expedited Appeals

Members have the right to request an expedited appeal within 90 calendar days of receipt of the denial letter. Expedited appeals are acknowledged by phone and in writing.

If Amerigroup denies a request for an expedited appeal, we must:

- Transfer the appeal to the time frame for standard resolution, which is 45 calendar days.
- Make a reasonable effort to give the member prompt verbal notice of the denial and follow up within two days with written notice.

Grievances and Appeals
Members: Response to Expedited Appeals

Amerigroup may request medical records or a provider explanation of the issues raised in an expedited appeal by:

- Phone

- Fax, with a signed and dated letter
- Mail, with a signed and dated letter

Providers are expected to comply with the request for additional information within 24 hours.

Grievances and Appeals

Members: Resolution of Expedited Appeals

Amerigroup resolves expedited appeals as quickly as possible and within 72 hours or three calendar days of the request. The member is notified by phone, whenever possible, as well as in writing within two days of the expedited appeal decision.

Grievances and Appeals

Members: Other Options for Filing Grievances

After exhausting Amerigroup 's grievances and appeals process, if a Member still is dissatisfied with the decision, the Member has the right to file a State Fair Hearing.

The member can file a State Fair Hearing or grievance with the IA Health Link Managed Care Ombudsman:

Office of Ombudsman
Ola Babcock Miller Building
1112 East Grand Ave.
Des Moines, IA 50319

Grievances and Appeals

Members: State Fair Hearing

Members may request a State Fair Hearing after they have exhausted all of Amerigroup's internal appeal processes. The request must be filed within 90 business days of the resolution letter. The request must be submitted in writing to the state of Iowa to:

Appeals Section, Bureau of Policy Analysis
Iowa Department of Human Services
Hoover State Office Building
Des Moines, IA 50319

The process is as follows:

- The state sends a notice of the hearing request to Amerigroup.
- Upon receipt of the request, we forward all documents related to the request to the state.
- The state of Iowa schedules a hearing within the county where the member lives.
- The state notifies all parties of the date, time and place of the hearing. Representatives from our administrative, medical and legal departments may attend the hearing to present testimony and arguments. Our representatives may cross-examine witnesses and offer rebutting evidence.
- An Administrative Law Judge renders a decision in the hearing within 90 business days of the date the hearing request was made.
- If the judge overturns Amerigroup's position, we must adhere to the judge's decision and ensure the decision is carried out.

Please note: If the member needs special arrangements to attend the hearing due to a disability, or needs English language translation services, please call:

Toll free: <1-800-338-8366> (Or, in Polk county, call <515-256-4606>)

Hours: Monday through Friday, from 8 a.m.-5 p.m. Central time

Please note: If the member needs help in filing a grievance or wants to know more about their rights, the member may call:

IA Health Link Member Services

Toll free: <1-800-338-8366> (Or, in Polk county, call <515-256-4606>)

Hours: Monday through Friday, from 8 a.m.-5 p.m. Central time

Email: IMEMemberServices@dhs.state.ia.us

Grievances and Appeals
Confidentiality

All grievances and appeals are handled in a confidential manner. We do not discriminate against a member for filing a grievance or requesting a State Fair Hearing. We notify members of our grievances and appeals process in the Member Handbook. Members may request a translated version in languages other than English.

Grievances and Appeals
Discrimination

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when an Amerigroup representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so, if the member requests assistance. We document, track and trend all alleged acts of discrimination.

Grievances and Appeals
Continuation of Benefits during Appeal

Members must file a request within 10 days of receiving a Notice of Action letter from Amerigroup regarding a decision to reduce, limit, terminate or suspend benefits. We will tell the member that they may be liable for the costs of that care if the DHS upholds our decision. If the member requests that we continue coverage, the following conditions apply:

- If the DHS reverses Amerigroup's decision, we are responsible for covering services provided during the administrative hearing process.
- If the DHS upholds Amerigroup's decision, we may pursue reimbursement for all services provided to the member, to the extent that services were rendered solely because of this requirement.

Amerigroup will continue to provide benefits until one of the following occurs:

- The member withdraws the appeal.
- The State Fair Hearing's decision is adverse to the member.
- Authorization expires or the authorization service is met.

Grievances and Appeals

Additional Options for Filing a Grievance

An additional avenue is open to members who want to file a grievance. Members may contact the Iowa Insurance Division at:

Iowa Insurance Division
601 Locust St., 4th Floor
Des Moines, IA 50309-3738
Phone: <515-281-5705>
Fax: <515-281-3059>
Toll-free consumer line: <1-877-955-1212>

CHAPTER 15: CREDENTIALING AND RE-CREDENTIALING

Provider Services: **<<1-800-454-3730>>**
Provider Services Fax: **<<1-800-964-3627>>**
Hours of Operation: **Monday to Friday, 7:30 a.m.-6 p.m. Central time**

Credentialing and Recredentialing
Overview

Credentialing is the process of validating the professional competency and conduct of providers and health delivery organizations. Providers and health delivery organizations must meet rigorous credentialing standards to be part of the Amerigroup Provider network. The credentialing process involves verifying licensure, board certification and education. The process also involves identifying malpractice or negligence claims through the applicable Iowa state agencies and the National Practitioner Database.

We require recredentialing every three years to stay current with your professional information. Recredentialing is also essential to our members, who depend on the accuracy of the information in the Amerigroup Provider Directory.

Amerigroup has streamlined the credentialing process by teaming up with the Council for Affordable Quality Healthcare (CAQH), nationally recognized for its thoroughness in collecting provider data.

Credentialing and Recredentialing
Council for Affordable Quality Healthcare

Amerigroup encourages Iowa providers to use CAQH's Universal Provider Datasource (UPD) for initial credentialing and periodic recredentialing. CAQH is a not-for-profit alliance of the nation's leading health care plans and networks whose mission is to improve health care quality and access for more than 165 million Americans covered by these plans. The CAQH data collection system of 800,000 providers allows administrative requirements to be streamlined.

The UPD is the industry standard for collecting the provider data used in credentialing. Providers in all 50 states and the District of Columbia are able to enter information free of charge, reducing paperwork for more than 550 participating health care plans. The UPD allows providers to fill out one application to meet the credentialing data needs of multiple organizations. For both Amerigroup and providers, recredentialing is helpful because this process:

- Supports Amerigroup administrative streamlining and paper reduction efforts.
- Helps to ensure the accuracy and integrity of the provider database.
- Simplifies the credentialing application process, eliminating redundant application forms and streamlining paperwork for providers.
- Enables providers to utilize the UPD database at no cost.

Our credentialing process for office-based providers is consistent with National Committee for Quality Assurance (NCQA) guidelines and the state of Iowa requirements to practice medicine.

Credentialing and Recredentialing

Approved Provider Types

Practitioners who fall within the scope of credentialing are strongly encouraged to use the CAQH application, with the exception of health delivery organizations. CAQH will accept providers from among the following approved provider types:

- Audiologist (AUD)
- Certified registered nurse anesthetist (CRNA)
- Christian science practitioner (CSP)
- Clinical nurse specialist (CNS)
- Clinical social workers
- Doctor of podiatric medicine (DPM)
- Doctor of chiropractic (DC)
- Doctor of osteopathy (DO)
- Licensed practical nurse (LPN)
- Massage therapist (MT)
- Medical doctor (MD)
- Midwife (MW)
- Naturopath (ND)
- Neuropsychologist (NEU)
- Nurse midwife (NMW)
- Nurse practitioner (NP)
- Nutritionist (LN)
- Occupational therapist (OT)
- Psychiatrists
- Psychiatric nurse practitioners
- Psychologists
- Registered nurse (RN)
- Registered nurse first assistant (RNFA)
- Respiratory therapist (RT)
- Speech pathologist (SLP)

Credentialing and Recredentialing

Approved Health Delivery Organizations

All health delivery organizations falling within the scope of credentialing are strongly encouraged to use the CAQH application. CAQH will accept health delivery organizations from among the following:

- Hospitals
- Behavioral health facilities
- Cardiac catheterization labs
- Free-standing surgical centers
- Home health agencies
- Lithotripsy centers (facilities for treating kidney stones)
- Skilled nursing facilities (nursing homes)

Credentialing and Recredentialing

CAQH/UPD Registration: First Time Users

Amerigroup providers must have a CAQH provider identification (ID) number to register and begin the credentialing process. Perform the following steps if you are not registered with CAQH:

1. After you obtain an Amerigroup provider record ID and submit a current signed Amerigroup agreement, CAQH will add your name to the roster.
2. You can log on to CAQH and register at **https://proview.caqh.org/login**.
3. When you receive your CAQH provider ID, go to the CAQH website to complete your application. Providers who do not have Internet access may submit their application via fax to CAQH by first contacting the CAQH Help Desk at <<1-888-600-9802>>.
4. After successfully authenticating key information, you will be able to create your own user name and unique password to begin using the CAQH UPD database.

Please note: Registration and completion of the online application are free.

Credentialing and Recredentialing

CAQH/UPD Registration: Completing the Application Process

The Universal Provider Datasource (UPD) standardized application is a single, standard online form that meets the needs of all participating health care organizations. When completing the application, indicate which participating health care plans and health care organizations you authorize to access your application data. All of the data you submit through the UPD service is maintained by CAQH in a secure data center.

The following materials will be helpful while completing the UPD online application:

- Previously completed credentialing application
- List of previous and current practice locations
- Various identification numbers (Universal Provider Identification Number [UPIN], NPI, Medicare, Medicaid, etc.)
- State license(s) applicable to your provider type
- Current Drug Enforcement Administration (DEA) certificate, if applicable
- Current Controlled and Dangerous Substances certificate, if applicable
- Internal Revenue Service (IRS) W-9 form(s)
- Current malpractice insurance face sheet
- Summary of all pending or settled malpractice cases within the past 10 years
- History of refusal or cancellation of professional liability insurance
- Curriculum vitae
- Disclosure of ownership

After completing the online credentialing application, you will be asked to:

- Authorize access to your information. Check the box next to Amerigroup or select the **Global Authorization** option.
- Verify your data entry and attestation for accuracy and completeness.
- Submit supporting documents:
  - State license(s) applicable to your provider type
  - Board certification or highest level of medical training or education
  - Work history
  - Admitting privileges at a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), National Integrated Accreditation for Healthcare Organizations (NIAHO), American Osteopathic Association (AOA) or a network hospital previously approved by the committee
  - Current DEA certificate or plan to prescribe if no DEA certificate, if applicable
  - Current Controlled and Dangerous Substances certificate, if applicable
  - Copy of the professional liability insurance face sheet is required. Organizational providers are required to maintain professional liability insurance in the amounts specified in the Network Provider Agreement consistent with State law requirements and Amerigroup policy.
  - Summary of all pending or settled malpractice case(s) within the past 10 years
  - Curriculum vitae
  - Current signed attestation
  - Written protocol (advanced nurse practitioners only)
  - Supervision form (physician assistants only)

- Hospital Coverage letter, required by Amerigroup from providers who do not have admitting privileges at a participating network hospital
- State or federal license sanctions or limitations
- Medicare, Medicaid or Federal Employees Health Benefits Program (FEHBP) sanctions
- Disclosure of Ownership

Fax these documents to CAQH at <<1-866-293-0414>>.

Please note: While the CAQH credentialing data set is substantially complete, Amerigroup may need to supplement, clarify or confirm certain responses on your application on a case-by-case basis. Providers may submit additional documentation by:

E-mail (preferred): **caqh.updaadmin@acsgs.com**
Fax: <<1-866-293-0414>>

If you have any questions about accessing the UPD database, you may contact the CAQH Help Desk for assistance at <1-888-600-9802>.

Credentialing and Recredentialing
CAQH/UPD Registration: Existing Users

If you are an existing CAQH/UPD user through participation in another health plan, log on to the UPD database and authorize Amerigroup to access your information by following these steps:

1. Go to the CAQH website at **http://upd.caqh.org/**
2. Under **Providers**, select **Go To Universal Provider Datasource**. Then, enter your username and password.
3. Click the **Authorize** tab located under the CAQH logo.
4. Scroll down, locate **Amerigroup** and check the box next to **Amerigroup**, or select the **Global Authorization** option.
5. Click **Save** to submit your changes.

For more information about the CAQH UPD database and application process, visit the CAQH website.

Credentialing and Recredentialing
Additional CAQH Resources

CAQH contact information is as follows:

Phone: <<1-888-599-1771>> (Monday through Thursday, 7 a.m.-9 p.m. Central time; Friday, 7 a.m.-7 p.m. Central time)
Email address: **caqh.updaadmin@acsgs.com**
Fax number for supporting documents: <<1-866-293-0414>>

Please note: Providers with vision and/or hearing challenges may call the CAQH Help Desk and complete the application by phone.

Credentialing and Recredentialing
Contracting Process for Hospital or Facility-Based Providers

Hospital or facility-based providers must submit a request for contracting and participating in the Amerigroup Medicaid networks. A facility-based provider application is available at the end of this chapter.

Eligible hospital or facility-based specialists include, but are not limited to:

- Anesthesiologist
- Emergency room provider
- Hospitalist
- Neonatologist
- Pathologist
- Radiologist

Hospital or facility-based providers must have the following:

- Hospital privileges
- Type 1 NPI number
- Iowa Medical Board license (temporary permit is acceptable) or appropriate Iowa licensure applicable to provider type Certificate/American Association of Nurse Anesthetists (AANA) number (applicable to CRNA Providers only)
- Certificate/AANA number (applicable to CRNA providers only)

Please note: Having an Amerigroup provider record ID does not automatically activate the Medicaid network. Claims will be processed out-of-network until the provider has applied for network participation and has been approved and activated in the Medicaid network.

To complete the contracting process, hospital or facility-based providers must take the steps outlined in the following sections, as appropriate.

Medical Group Adding a Provider

If you are part of a medical group with a Group Medicaid Agreement and this group is adding you as a facility-based provider: Complete and fax the Medicaid Facility-Based Provider application to your local Network Management office for processing.

Provider or Medical Group Interested in Contracting with Amerigroup Iowa, Inc.

If you are a provider or a medical group interested in contracting as a facility-based provider with the Medicaid network, and you do not currently have a Medicaid Agreement:

1. Complete the Online Agreement Request form. Or, request an agreement be mailed or faxed to you by contacting your local Network Management office.
2. Complete and sign either of the following documents:
    - Provider or Medical Group Agreement (as applicable). Return to your local Network Management office.
    - Medicaid Facility-Based Provider application. Return to your local Network Management office. Access instructions are at the end of this chapter.

Credentialing and Recredentialing

Credentialing Updates

You must inform CAQH and Amerigroup of changes to your practice so that our members rely on the accuracy of the information in our online Provider Directory. CAQH will send you automatic reminders to review and attest to the accuracy of your data every 4 months. If you are a participating provider, submit

most changes online by using the Change Your Information form available on the CAQH website at **http://upd.caqh.org/**.

Credentialing and Recredentialing
Recredentialing

When you are scheduled for recredentialing, Amerigroup sends your name on the Amerigroup roster of providers to CAQH. We determine if you have completed the UPD credentialing process and have authorized Amerigroup to access your information or selected the **Global Authorization** option. If you have made this authorization, Amerigroup obtains your current information from the UPD database and completes the recredentialing process without contacting you.

If your recredentialing application is not available to Amerigroup through CAQH for any reason, CAQH mails you a Welcome Kit with access and registration instructions along with your personal CAQH provider ID. You may then obtain immediate access to the UPD database via the Internet to complete and submit your application. For detailed instructions, go to the section **CAQH/UPD Registration: Existing Users** in this chapter. After you have granted access to Amerigroup, recredentialing resumes.

Please note: You must enter your changes into the UPD database and authorize access to Amerigroup during the credentialing and recredentialing process. Only health care plans participating in the UPD database and those to which you have granted access receive these changes.

Credentialing and Recredentialing
Ownership Disclosure

As part of the initial and subsequent recredentialing process, Amerigroup follows the CMS process regarding ownership disclosure. You periodically may be required to submit a Disclosure of Ownership questionnaire, located on the CMS website at **www.cms.gov.**

Credentialing and Recredentialing
Professional Liability Coverage

To the extent allowed under applicable law or State agency requirements, verification of professional liability insurance coverage may be accomplished by the use of an attestation signed by the provider indicating the name of the carrier, policy number, coverage limits, the effective date and expiration date of such insurance coverage.

If attestation is not acceptable, the practitioner's professional liability insurance information is verified by obtaining a copy of the professional liability insurance face sheet from the practitioner or from the insurance carrier. Practitioners are required under applicable law to maintain professional liability insurance in specified amounts. The application form must include specific questions regarding the dates and amount of a practitioner's current malpractice insurance. NCQA requires practitioners to attest to the dates and amount of their current malpractice coverage, even if the amount is $0.

CHAPTER 16: ACCESS STANDARDS AND ACCESS TO CARE

Provider Services: **<<1-800-454-3730>>**
Provider Services Fax: **<<1-800-964-3627>>**
Hours of Operation: **Monday to Friday, 7:30 a.m.-6 p.m. Central time**

Access Standards and Access to Care
Overview

This chapter outlines Amerigroup's standards for timely and appropriate access to quality health care. Following guidelines set by the National Committee for Quality Assurance (NCQA), the American College of Obstetricians and Gynecologists (ACOG) and the Iowa Department of Human Services (DHS), these standards help ensure that medical appointments, emergency services and continuity of care for new and transferring members are provided fairly, reasonably and within specific time frames.

We recognize that cultural and linguistic barriers may affect our members' ability to understand or comply with certain instructions or procedures. To break through those barriers and ensure that our access standards can be met, we encourage providers to access Amerigroup's Cultural Competency Toolkit and Cultural and Linguistic Training. Locate this information on the **Providers** page of our website at providers.amerigroup.com/ia under **Provider Education**. Or, for additional information on cultural diversity and interpreter services, please refer to **Chapter 22: Cultural Diversity and Linguistic Services** in this manual.

Amerigroup monitors provider compliance with access to care standards on a regular basis. Failure to comply may result in corrective action.

Access Standards and Access to Care
General Appointment Scheduling

Urgent, nonemergent: The existence of conditions due to an illness or injury which are not life threatening but which require expeditious treatment because of the prospect of the condition worsening without clinical intervention.

Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Iowa Medicaid requires providers to comply with the following standards:

Nature of Visit	Appointment Standards
Emergent or emergency visits	Immediately upon presentation, 24 hours a day, 7 days a week and without preauthorization
PCP urgent visits	Within 24 hours

PCP routine visits	Not to exceed four (4) to six (6) weeks from the date of a patient's request for a routine
Persistent symptoms	Within 48 hours
Specialist urgent visit	Within 24 hours
Specialist routine visit	Within 30 calendar days
Initial visit for pregnant women	Within 14 calendar days
Behavioral health urgent, nonemergency	Within one (1) hour of presentation at a service delivery site or within 24 hours of telephone contact with provider or the contractor
Behavioral health emergency	Within 15 minutes of arrival
Behavioral health mobile crisis	Within one (1) hour of presentation or request
Behavioral health persistent symptoms	Within 48 hours of reposting symptoms
Behavioral health routine	Within three (3) weeks of requesting appointment
Substance use disorder and pregnancy	Within 48 hours of seeking treatment
Intravenous drug use	No later than 14 days after making the request for admission, or 120 days after the date of such request if no program has the capacity to admit the individual on the date of such request, and if interim services are made available to the individual no later than 48 hours after such request.

Access Standards and Access to Care

Services for Members under the Age of 21

Amerigroup strongly recommends that our members see their PCP as soon as possible after enrollment.

Nature of Visit	Appointment Standards
Initial Health Assessments (IHAs)	Newborns: within 14 days of enrollment Children: within 60 days of enrollment Adults (18-21): within 90 days of enrollment
Preventive care visits	Based on the American Academy of Pediatrics (AAP) Periodicity Schedule found within the Preventive Health Guidelines

Access Standards and Access to Care
Services for Members 21 Years and Older

Nature of Visit	Appointment Standards
Initial Health Assessments (IHAs)	Within 90 days of enrollment
Preventive care visits after initial diagnosis	Within 60 days of request

Access Standards and Access to Care
Prenatal and Postpartum Visits

Nature of Visit	Appointment Standards
Prenatal	Within 14 days of request
Third trimester	Within 5 business days of request, or immediately if an emergency
High-risk pregnancy	Within 14 business days of request, or immediately if an emergency
Postpartum exam	Between 3-8 weeks after delivery

Access Standards and Access to Care
Wait Times

When a provider's office receives a call from an Amerigroup member during regular business hours for assistance and possible triage, the provider or another health care professional must take or return the call within 30 minutes.

Access Standards and Access to Care
Nondiscrimination Statement

Providers must post a statement in their offices detailing hours of operation. These hours of operation must not discriminate against Amerigroup members enrolled in IA Health Link. The statement must include the following:

- Waiting times for appointments
- Waiting times for care at facilities
- Languages spoken

Access Standards and Access to Care
Interpreter Services

Amerigroup will ensure that members who need interpreter services have access to interpreter 24 hours a day, 7 days a week. Services include, but are not limited to, assistance during office visits.

Amerigroup providers should strongly discourage the use of minors, friends and family members acting as interpreters.

To request interpreter services during business hours:

- Providers call Provider Services at <<1-800-454-3730>>
- Members call Member Services at <<1-800-600-4441>>

To request interpreter services after hours:

- Providers and members call our Amerigroup On Call at:
  - Phone: <<1-800-600-4441>> (24 hours a day, 7 days a week)
  - TTY: <<711>>

Please note: To schedule face-to-face interpreter services, please allow 72 hours. To cancel, please provide a 24-hour notice.

Access Standards and Access to Care
Missed Appointment Tracking

When members miss appointments, providers must do the following:

- Document the missed appointment in the member's medical record.
- Make at least three attempts to contact the member to determine the reason for the missed appointment.
- Provide a reason in the member's medical record for any delays in performing an examination, including refusals by the member.

Access Standards and Access to Care
After-Hours Services

Amerigroup's policy, and the state of Iowa's requirement, is for our members to have access to quality health care services 24 hours a day, 7 days a week. This kind of access means PCPs must have a system in place to ensure members may call after-hours with medical questions or concerns. Amerigroup monitors PCP compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action.

PCPs must adhere to the answering service and answering machine protocols defined in the following sections.

Answering Service

Answering service or after-hours personnel must:

- Forward member calls directly to the PCP or an on-call provider, or instruct the member that the provider will contact the member within 30 minutes.
- Ask the member if the call is an emergency. In the event of an emergency, immediately direct the member to dial 911 or proceed to the nearest hospital emergency room.
- Have the ability to contact a telephone interpreter for members with language barriers.
- Return all calls.

Answering Machine Messages

- May be used when provider office staff or an answering service is not immediately available.
- Must instruct members with emergency health care needs to dial 911 or proceed to the nearest hospital emergency room.
- Must provide instructions on how to contact the PCP or an on-call provider in a nonemergency situation.
- Must provide instructions in English, Spanish and any other language appropriate to the PCP's practice.

We offer the following suggested text for answering machines:

"Hello, you have reached *[insert physician office name*]. If this is an emergency, hang up and dial 911 or go to the nearest hospital emergency room. If this is not an emergency and you have a medical concern or question, please call *[insert contact phone or pager number*]. You will receive a return call from the on-call physician within *[timeframe]*."

Please note: Amerigroup prefers that PCPs use an in-network provider for on-call services. When this is not possible, PCPs must use their best efforts to ensure the covering on-call provider abides by the terms of the Provider Agreement.

Access Standards and Access to Care
Amerigroup On Call

Members may call Amerigroup On Call, our 24/7 information phone line, any time of the day or night, to speak to a registered nurse. Nurses provide health information and options for any of the following:

- Authorization requests
- Emergency instructions
- Health concerns
- Local health care services
- Medical conditions
- Prescription drugs
- Transportation needs
- Access to interpreter services

Phone: <<1-800-454-3730>>
TTY: <<711>>
TTY: <<1-800-855-2884 (711?)>> (Spanish)

Access Standards and Access to Care
Continuity of Care

Amerigroup provides continuity of care for members with qualifying conditions when health care services are not available within the network or when the member or provider is in a state of transition.

> **Qualifying condition:** A medical condition that may qualify a member for continued access to care and continuity of care.

Qualifying conditions include, but are not limited to:

- Acute conditions (for example, cancer)
- Degenerative and disabling conditions or diseases caused by a congenital or acquired injury or illness requiring a specialized rehabilitation program or a high level of service, resources or coordination of care in the community.
- Newborns, who are covered retroactively to the date of birth

- Organ transplant or tissue replacement
- Pregnancy, with 12 weeks or less remaining before the expected delivery date, through immediate postpartum care
- Scheduled inpatient/outpatient surgery that was approved and/or precertified through the applicable DHS process
- Serious chronic conditions (hemophilia, for example)
- Terminal illness

States of transition may be when the member is:

- Newly enrolled
- Moving out of the service area
- Disenrolling from Amerigroup to another health plan
- Exiting Amerigroup to receive excluded services
- Hospitalized on the effective date of transition
- Transitioning through behavioral health services
- Scheduled for appointments within the first month of plan membership with specialists. These appointments must have been scheduled prior to the effective date of membership.

A state of transition also is applicable when the provider's contract terminates.

Amerigroup providers help ensure continuity and coordination of care through collaboration. This includes the confidential exchange of information between PCPs and specialists as well as behavioral health providers. In addition, Amerigroup coordinates care when the provider's contract has been discontinued to facilitate a smooth transition to a new provider.

Providers must maintain accurate and timely documentation in the member's medical record including, but not limited to:

- Consultations
- Precertification
- Referrals to specialists
- Treatment plans

All providers share responsibility in communicating clinical findings, treatment plans, prognosis and the member's psychosocial condition as part of the coordination of care process. Medical Management nurses review member and provider requests for continuity of care. These nurses facilitate continuation with the current provider until a short-term regimen of care is completed or the member transitions to a new provider.

Please note: Only Amerigroup can make adverse determination decisions regarding continuity of care.

Adverse determination decisions are sent in writing to the member and provider within two business days of the decision. Members and providers may appeal the decision by following the procedures in **Chapter 12: Grievances and Appeals** in this manual. Reasons for continuity of care denials include, but are not limited to the following:

- Course of treatment is complete
- Member is ineligible for coverage
- Condition is not a qualifying condition
- Request is for change of PCP only and not for continued access to care
- Requested services are not covered

- Services rendered are covered under a global fee
- Treating provider currently is contracted with our network

Please note: Amerigroup does not impose any pre-existing condition limitations on its Medicaid members, nor require evidence of insurability to provide coverage to any of our members.

Access Standards and Access to Care
Provider Contract Termination

Amerigroup will arrange for continuity of care for members affected by a provider whose contract is terminated. A terminated provider actively treating members must continue to treat members until the date of termination. PCPs must give at least 90 days advance notice and specialists must give at least 120 days advance notice before terminating the Provider Agreement. The exception is when the PCP or primary care clinic (PCC) provides 30 percent or more of Amerigroup services, in which case the PCP or PCC must give at least 120 days advance notice.

After Amerigroup receives a provider's notice to terminate a contract, we notify all impacted members. We send a letter at least 15 days in advance to inform the affected members about the:

- Impending termination of their provider
- Member's right to request continued access to care
- Member Services phone number to make PCP changes and/or forward referrals to Medical Management for continued access to care consideration

Members under the care of specialists may also submit requests for continued access to care, including continued care after the transition period. Members should contact Member Services at <1-800-600-4441>.

Access Standards and Access to Care
Newly Enrolled

Our goal is to ensure that the health care of our newly enrolled members is not disrupted or interrupted. Amerigroup ensures continuity of care for our newly enrolled members when the member's health or behavioral health condition has been treated by specialists. We also ensure continuity of care when the member's health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted.

Amerigroup will pay a newly enrolled member's existing out-of-network provider for medically necessary covered services until that regimen of care is completed. The member's records, clinical information and care are transferred to an Amerigroup provider.

Payment to out-of-network providers is made within the same time period required for providers within the network. In addition, we comply with out-of-network provider reimbursement rules as adopted by the DHS. However, we are not obligated to reimburse the member's existing out-of-network providers for on-going care if the time elapsed has been greater than:

- 90 days after the member enrolls in Amerigroup
- Nine months after the member enrolls in Amerigroup, if the member was diagnosed with a terminal illness at the time of enrollment in our plan and has been receiving ongoing treatment for the illness

All new enrollees receive evidence of coverage (EOC) membership information in their enrollment packets, which provides information regarding members' rights to request continuity of care.

Access Standards and Access to Care
Members Moving Out of Service Area

If a member moves out of the service area, Amerigroup will continue to provide emergency services until the member chooses a new managed health care plan.

Access Standards and Access to Care
Second Opinions

Amerigroup will help to ensure that members have access to a second opinion regarding any medically necessary covered service. When the request involves care from a specialist, a provider of the same specialty must give the second opinion. When no provider exists within the network who meets the qualification, Amerigroup may authorize a second opinion by a qualified out-of-network provider. This service is provided at no cost to the member.

Access Standards and Access to Care
Emergency Transportation

Amerigroup covers emergency transportation services without precertification. When a member's condition is life-threatening and requires use of special equipment, life support systems and close monitoring by trained attendants while en route to the nearest appropriate facility, we will provide emergency transport by ambulance.

Examples of conditions considered for emergency transport include, but are not limited to:

- Acute and severe illnesses
- Acute or severe injuries from auto accidents
- Extensive burns
- Loss of consciousness
- Semi-consciousness, seizure, or cardiopulmonary resuscitation (CPR) treatment during transport
- Untreated fractures

Emergency transportation is also available for facility-to-facility transfers when the required emergency treatment is not available at the first facility.

Access Standards and Access to Care
Emergency Dental Services for Adults and Children

When a member has a dental emergency resulting in swelling, fever, infection or injury to the jaw, natural teeth, mouth or face, Amerigroup covers the initial dental work and oral surgery, including anesthesia and drugs, for services provided in the following settings:

- Outpatient
- Doctor's office
- Emergency care
- Urgent care

The services are limited to the care needed to give proper treatment. Injury as a result of chewing or biting is not considered an accidental injury. Initial dental work refers to services provided within 48 hours of the

injury, or as soon as possible. Covered services include all exams and treatment to complete the repair, such as:

- Anesthesia
- Lab tests
- Mandibular/maxillary reconstruction
- Oral exams
- Oral surgery
- Prosthetic services
- Restorations
- X-rays

Access Standards and Access to Care

Border City Providers

Some cities outside of the state of Iowa but within 50 miles of the Iowa border are designated as “Border Cities”. Eligible providers practicing outside of Iowa but within a border city-designated area may enroll with Amerigroup for the provision of services to IAHealth Link members. Such enrollment will not require Iowa licensure but the provider must meet the licensing requirements of the state in which they are providing the services and obtain an Iowa Medicaid identification number.

CHAPTER 17: PROVIDER ROLES AND RESPONSIBILITIES

Provider Services: **<<1-800-454-3730>>**
Provider Services Fax: **<<1-800-964-3627>>**
Hours of Operation: **Monday to Friday, 7:30 a.m.-6 p.m. Central time**

Provider Roles and Responsibilities
Overview

At Amerigroup, our goal is to provide quality health care to the right member, at the right time and in the appropriate setting. To achieve this goal, PCPs, specialists and ancillary providers must fulfill their roles and responsibilities with the highest integrity. We rely on your extensive health care education, experience and dedication to our members, who look to you to get well and stay well.

Provider Roles and Responsibilities
Primary Care Physicians

PCPs are the principle point of contact for our members. The PCP's role is to provide members with a health "home", the member's first stop in the health care process and a centralized hub for a wide variety of ongoing health care needs. Amerigroup furnishes PCPs with a current list of assigned members. The PCP's role is to:

- Coordinate members' health care 24 hours a day, 7 days a week
- Develop members' care and treatment plans, including preventive care
- Maintain members' current medical records, including documentation of all services provided by the PCP, specialists, or referral services
- Adhere to wait times, as outlined within the Provider Agreement and Provider Manual
- Refer members to specialists
- Coordinate with outpatient clinical services
- Provide complete information about proposed treatments and prognosis for recovery to our members or their representatives
- Facilitate interpreter services by presenting information in a language that our members or their representatives can understand
- Ensure that members' medical and personal information is kept confidential as required by state and federal laws

The PCP's scope of responsibilities includes providing or arranging for:

- Routine and preventive health care services
- Emergency care services
- Hospital services
- Ancillary services
- Interpreter services
- Referrals to specialists
- Coordination with outpatient clinical services, such as therapeutic, rehabilitative or palliative services

Please note: Services should always be provided without regard to race, religion, sex, color, national origin, age or physical/behavioral health status.

Amerigroup members may select any contracted provider as their PCP as long as that provider is taking new patients. We keep providers up-to-date with detailed member information. We also furnish each provider with a current list of assigned members and provide medical information about the members' potential health care needs. Providers may use this information to coordinate treatment and services more effectively.

PCPs should provide services only to those Amerigroup members who have chosen you as their PCP. Verify that a member is assigned to you using any of the following methods:

- Call Provider Services at <<1-800-454-3730>>
  - Use the automated voice response (AVR) system to verify PCP assignment
  - Speak to a Member Services representative
- Log into Availity, the secure provider portal on the **Providers** page of our website at **providers.amerigroup.com**/ia. Click on **Login** or **Register** to access the site.

You may experience delays in claims payments if you treat members who are not assigned to you on the date of service. If you must provide services to an Amerigroup member not assigned to you, obtain precertification first. Noncontracted providers must obtain precertification before treating Amerigroup members.

Provider Roles and Responsibilities
Referrals

PCPs coordinate and make referrals to specialists, ancillary providers and community services. Providers should refer members to network facilities and providers. When this is not possible, providers should follow the appropriate process for requesting out-of-network referrals.

Please note: Specialty referrals to network providers do not require precertification.

All PCPs must perform the following with regard to referrals:

- Help members schedule appointments with other health care providers, including specialists.
- Track and document appointments, clinical findings, treatment plans and care received by members referred to specialists or other health care providers.
- Refer members to health education programs and community resource agencies, when appropriate.
- Coordinate with the Women, Infants and Children (WIC) program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin.
- Coordinate with the local tuberculosis (TB) control program to ensure that all members with confirmed or suspected TB have a contact investigation and receive directly observed therapy (DOT).
- Report any member who is noncompliant, drug resistant or who is or may be posing a public health threat to the Iowa Department of Human Services (DHS) or the local TB control program.
- Perform screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

Provider Roles and Responsibilities
Out-Of-Network Referrals

We recognize that an out-of-network referral may be justified at times. The Amerigroup Medical Management department will work with the PCP to determine medical necessity and will authorize out-of-network referrals on a limited basis. For assistance, contact the Medical Management department at:

Phone: <<1-800-454-3730>>
Fax: <1-800-964-3627>

Provider Roles and Responsibilities

Interpreter Services

Providers must notify members of the availability of interpreter services. Providers also must train their answering services and on-call personnel on how to access those services. Amerigroup providers should strongly discourage the use of minors, friends and family members acting as interpreters. Providers also must accommodate non-English speaking members by having multilingual messages on answering machines.

For those instances when you cannot communicate with a member due to language barriers, telephonic and face-to-face interpreter services are available at no cost to you or the member. Request telephonic interpreters for members needing language assistance as outlined below:

During business hours:

- Providers call Provider Services at <<1-800-454-3730>>.
- Members call Member Services at <<1-800-600-4441>>.

After-hours, providers and members call our Amerigroup On Call:

- Phone: <<1-800-454-3730>> (24 hours a day, 7 days a week)
- TTY: <<711>>

Request face-to-face interpreters for members needing language assistance, including American Sign Language, as outlined below:

During business hours:

- Providers call Provider Services at <<1-800-454-3730>>.
- Members call Member Services at <<1-800-600-4441>> (TTY 711).

Please note: To schedule face-to-face interpreter services, please allow 72 hours. To cancel, please provide a 24-hour notice.

Provider Roles and Responsibilities

Transitioning Members between Medical Facilities and Home

When medically indicated, the PCP initiates or assists with the discharge or transfer of members:

- From an inpatient facility to the appropriate skilled nursing or rehabilitation facility, or to the member's home.
- From an out-of-network hospital to an in-network hospital, or to the member's home with home health care assistance (within benefit limits).

The coordination of member transfers from non-contracted, out-of-network facilities to contracted, in-network facilities is a priority that may require the immediate attention of the PCP. Contact the Amerigroup Medical Management department to assist in this process at:

Phone: <<1-800-454-3730>>
Fax: <<1-800-964-3627>>

Provider Roles and Responsibilities
Noncovered Services

All PCPs must inform members of the costs associated with noncovered services prior to rendering the noncovered services. For more information, call Provider Services at <<1-800-454-3730>>.

Provider Roles and Responsibilities
Specialists

Specialists, licensed with additional training and expertise in a specific field of medicine, supplement the care given by PCPs. Specialists are charged with the same responsibilities as PCPs, including the responsibility of ensuring that precertification has been obtained before rendering services.

Access to specialty care begins when the PCP refers a member to a specialist for medically necessary conditions beyond the PCP's scope of practice. Specialists diagnose and treat conditions specific to their area of expertise.

Please note: Specialty care is limited to Amerigroup benefits.

The following guidelines are in place for specialists:

- For urgent care, the specialist should see the member within 24 hours of receiving the request.
- For routine care, the specialist should see the member within two weeks of receiving the request.

In some cases, a member may self-refer to a specialist. These cases include, but are not limited to:

- Family planning and evaluation
- Diagnosis, treatment and follow-up of sexually transmitted infections (STIs)

For some medical conditions, the Specialist should be the PCP. Members may request that the specialist be assigned as their PCP if the member:

- Has a chronic illness
- Has a disabling condition
- Is a child with special health care needs

Provider Roles and Responsibilities
Hospital Scope of Responsibilities

PCPs refer members to plan-contracted network hospitals for medically necessary conditions beyond the PCP's scope of practice. Hospital care is limited to Amerigroup benefits. Hospital professionals diagnose and treat conditions specific to their area of expertise. Hospital responsibilities include:

- Notification of admission and services
- Notification of observations
- Notification of precertification review decision

Refer to the following sections for specific information.

Notification of Admission and Services

The hospital must notify Amerigroup or the review organization of an admission or service at the time the member is admitted or the service is rendered. If the member is admitted or a service is rendered on a day

other than a business day, the hospital must notify Amerigroup of the admission or service the morning of the next business day.

Notification of Observations

If our member is admitted to the hospital or for observation, this will be flagged in our census, and we will deploy discharge planning and care coordination through our Utilization Management staff. If the member is released home and we are notified by the hospital, PCP or member, Case Management will conduct outreach to coordinate required follow-up care and outreach within a week.

Notification of Precertification Decisions

If the hospital has not received notice of precertification at the time of a scheduled admission or service, as required by the Utilization Management Guidelines and the Hospital Agreement, the hospital should contact Amerigroup and request the status of the decision.

Any admission or service requiring precertification that has not received the appropriate review may be subject to post-service review denial. Generally, providers are required to perform all precertification functions with Amerigroup. Before rendering services, the hospital must ensure that precertification has been granted or risk post-service denial.

Provider Roles and Responsibilities
Ancillary Scope of Responsibilities

PCPs and specialists refer members to plan-contracted network ancillary providers for medically necessary conditions beyond the PCP's or specialist's scope of practice. Ancillary providers diagnose and treat conditions specific to their area of expertise. Ancillary care is limited to Amerigroup benefits.

We have a wide network of participating health care professionals and facilities. All services provided by the health care professional, and for which the health care professional is responsible, are listed in the Ancillary Agreement.

Provider Roles and Responsibilities
Responsibilities Applicable to All Providers

The responsibilities applicable to all Amerigroup providers include:

- After-hours services
- Collaboration
- Confidentiality
- Continuity of care
- Disenrollees
- Eligibility verification
- Licenses and certifications
- Mandatory reporting of abuse
- Medical records standards and documentation
- Office hours
- Open clinical dialog/affirmative statement
- Oversight of non-physician practitioners

- Precertification
- Prohibited activities
- Provider contract terminations
- Termination of ancillary provider/patient relationship
- Updating provider information

Provider Roles and Responsibilities

Office Hours

To maintain continuity of care, providers are required to be available for a minimum of 24 hours each week. Office hours must be clearly posted and members must be informed about the provider's availability at each site. There are strict guidelines for providing access to health care 24 hours a day, 7 days a week:

- Providers must be available 24 hours a day by phone.
- An on-call provider must be available to take calls when a provider is not available.

Provider Roles and Responsibilities

After-Hours Services

All PCPs must have an after-hours system in place to ensure that our members can call with medical concerns or questions after normal office hours. The answering service or after-hours personnel must forward member calls directly to the PCP or on-call provider, or instruct the member that the provider will be in contact within 30 minutes.

Emergencies

The answering service or after-hours personnel must ask the member if the call is an emergency. In the event of an emergency, the member must be directed to dial 911 or to proceed to the nearest hospital emergency room immediately.

If the PCP's staff or answering service is not available, an answering machine may be used. The answering machine message must instruct members with emergency health care needs to dial 911 or go directly to the nearest hospital emergency room. The message also must give members an alternative contact number to reach the PCP or on-call provider with medical concerns or questions.

Language-Appropriate Messages

Non-English speaking members who call their PCP after-hours should expect to get language appropriate messages. In the event of an emergency, these messages should direct the member to dial 911 or proceed to the nearest hospital emergency room immediately. In a nonemergency situation, members should receive instructions on how to contact the on-call provider. If an answering service is used, the service should know where to contact a telephone Interpreter. All calls taken by an answering service must be returned.

Network On-Call Providers

Amerigroup prefers that PCPs use network providers for on-call services. When that is not possible, the PCP must ensure that the covering on-call provider or other provider abides by the terms of the Provider

Agreement. Amerigroup will monitor PCP compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action.

Amerigroup On Call

Members may call our Amerigroup On Call 24 hours a day, 7 days a week to speak to a registered nurse. These nurses provide health information regarding illness, options for accessing care and availability of emergency services.

Phone: <<1-800-454-3730>>
TTY: <<711>>

Provider Roles and Responsibilities
Licenses and Certifications

Providers must maintain all licenses, certifications, permits, accreditations or other prerequisites required by Amerigroup and federal, state and local laws for providing medical services.

Provider Roles and Responsibilities
Eligibility Verification

All providers must verify member eligibility immediately before providing services, supplies or equipment. Because eligibility may change monthly, a member eligible on the last day of the month may not be eligible on the first day of the following month. Amerigroup is not responsible for charges incurred by ineligible patients. As part of the Primary Medical Group (PMG) lock-in program, a member's PMG assignment also must be verified. Services are considered for payment if rendered by a provider affiliated with the assigned group.

Provider Roles and Responsibilities
Collaboration

Providers share the responsibility of giving respectful care, working collaboratively with Amerigroup specialists, hospitals, ancillary providers, and members and their families. Providers must allow Amerigroup to use performance data in cooperation with Quality Improvement programs and activities. Providers must permit members to participate actively in decisions regarding medical care, including, except as limited by law, their decision to refuse treatment.

Provider Roles and Responsibilities
Continuity of Care

PCPs maintain frequent communication with specialists, hospitals and ancillary providers to ensure continuity of care. Amerigroup encourages providers to maintain open communication with their patients regarding appropriate treatment alternatives, regardless of their benefit coverage limitations. PCPs are responsible for being an ongoing source of primary care appropriate to the member's needs.

We have established comprehensive mechanisms to ensure continued access to care for members when providers leave our health care program. Under certain circumstances, members may finish a course of treatment with the terminating provider. For more information, refer to **Chapter 14: Access Standards and Access to Care** in this manual.

Provider Roles and Responsibilities
Medical Records Standards

Medical records must be maintained in a manner ensuring effective and confidential member care and quality review. At Amerigroup, we perform medical record reviews upon signing a provider contract. We then perform medical record reviews at least every three years to ensure that providers remain in compliance with these standards.

Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act. This act prohibits a provider of health care from disclosing any individually identifiable information regarding a patient's medical history, treatment, or behavioral and physical condition, without the patient's or legal representative's consent or specific legal authority.

Records required through a legal instrument may be released without patient or patient representative consent. Providers must be familiar with the security requirements of HIPAA and be in compliance. For more information on medical records standards, please refer to **Chapter 18: Quality Assessment and Performance** in this manual.

Provider Roles and Responsibilities
Mandatory Reporting of Child Abuse, Elder Abuse or Domestic Violence

Providers must ensure that their office staff is familiar with local reporting requirements and procedures regarding telephone and written reporting of known or suspected cases of abuse. All health care professionals must report any actual or suspected child abuse, elder abuse or domestic violence immediately to the local law enforcement agency by telephone. In addition, providers must submit a follow-up written report to the local law enforcement agency within the time frames required by law.

Provider Roles and Responsibilities
Updating Provider Information

Providers are required to inform Amerigroup of any material changes to their practice, including:

- Change in their professional business ownership
- Change in their business address or the location where services are provided
- Change in their federal 9-digit tax identification number (TIN)
- Change of their specialty
- Services offered to children
- Languages spoken
- Change in demographic data
- Legal or governmental action initiated against a health care professional. This type of action includes, but is not limited to, an action for professional negligence, for violation of the law or against any license or accreditation which, if successful, would impair the ability of the health care professional to carry out the duties and obligations under the Provider Agreement
- Other problems or situations that impair the ability of the health care professional to carry out the duties and obligations under the Provider Agreement's care review and grievance resolution procedures
- Notification that the provider is accepting new patients

To notify Amerigroup of changes, providers should call Provider Services at <<1-800-454-3730>>.

Provider Roles and Responsibilities
Oversight of Non-Physician Practitioners

All providers using non-physician practitioners must supervise and oversee non-physician practitioners consistent with state and federal laws. The supervising provider and the non-physician practitioner must have written guidelines for adequate supervision. All supervising providers must follow state licensing and certification requirements. Non-physician practitioners include the following categories:

- Advanced registered nurse practitioners
- Certified nurse midwives
- Physician assistants

These non-physician practitioners are licensed by the state and work under the supervision of a licensed Physician, as mandated by state and federal regulations.

Provider Roles and Responsibilities
Open Clinical Dialogue/Affirmative Statement

Nothing within the Provider Agreement or this manual should be construed as encouraging providers to restrict medically necessary covered services or limit clinical dialog between providers and their patients. Providers may communicate freely with members regarding the available treatment options, including medications, regardless of benefit coverage limitations.

Provider Roles and Responsibilities
Provider Contract Termination

A terminated provider actively treating members must continue treatment until the termination date. The termination date is the end of the 90-day period following written notice of termination, or according to a timeline determined by the medical group contract.

After we receive a provider's notice to terminate a contract, we notify members impacted by the termination. Amerigroup sends a letter to inform affected members about the:

- Impending termination of their provider
- Member's right to request continued access to care
- Member Services phone number to request PCP changes
- Referrals to Medical Management for continued access to care consideration

Members under the care of specialists may also submit requests for continued access to care, including after the transition period, by calling Member Services at:

Phone: <<1-800-600-4441>>
TTY: <<711>>

Amerigroup may terminate the Provider Agreement if we determine that the quality of care or services given by a health care provider is not satisfactory. We make this determination by reviewing member satisfaction surveys, case management data, member complaints or grievances, other complaints or lawsuits alleging professional negligence and quality of care indicators.

Provider Roles and Responsibilities
Termination of the Ancillary Provider/Patient Relationship

Under certain circumstances, an ancillary provider may terminate the professional relationship with a member, as provided for and in accordance with the provisions of this manual. However, ancillary providers may not terminate the relationship because of the member's medical condition or the amount, type or cost of covered services required by the member.

Provider Roles and Responsibilities
Disenrollees

When a member disenrolls and requests a transfer to another health plan, providers are expected to work with Amerigroup case managers responsible for helping the member make the transition. This transition must occur without disruption of any regimen of care that qualifies as a continuity of care condition. The case manager will coordinate with the member, the member's providers and the case manager at the new health plan to ensure an orderly transition.

Provider Roles and Responsibilities
Provider Rights

Amerigroup providers, acting within the lawful scope of practice, shall not be prohibited from advising a member or advocating on behalf of a member for any of the following:

- The member's health status, medical care or treatment options, including any alternative, self-administered treatment
- Any information the member needs to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or non-treatment
- The member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions
- To receive information on the Grievances and Appeals and State Fair Hearing procedures
- To have access to policies and procedures covering authorization of services
- To be notified of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested
- To challenge, on behalf of our members, the denial of coverage, or payment for, medical assistance
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable law solely based on that license or certification

Amerigroup's provider selection policies and procedures do not discriminate against particular providers who serve high-risk populations or specialize in conditions requiring costly treatment.

Provider Roles and Responsibilities
Prohibited Activities

All providers are prohibited from:

- Billing eligible members for covered services
- Segregating members in any way from other persons receiving similar services, supplies or equipment
- Discriminating against Amerigroup members or Medicaid participants

Provider Roles and Responsibilities

Misrouted Protected Health Information

Important note: You are not permitted to use or disclose Protected Health Information about individuals that you are not currently treating or have enrolled to your practice. This applies to Protected Health Information accessible in any Amerigroup online tool, or sent in any medium including mail, email, fax or other electronic transmission.

CHAPTER 18: CLINICAL PRACTICE AND PREVENTIVE HEALTH CARE GUIDELINES

Provider Services: **<<1-800-454-3730>>**
Provider Services Fax: **<<1-800-964-3627>>**
Hours of Operation: **Monday to Friday, 7:30 a.m.-6 p.m. Central time**

Clinical Practice and Preventive Health Care Guidelines

Overview

At Amerigroup, we believe that providing quality health care should not be limited to the treatment of injury or illness. We are committed to helping providers and members become more proactive in the quest for better overall health. To accomplish this goal, we offer providers tools to assist in finding the best, most cost-effective ways to:

- Provide member treatment
- Empower members through education
- Encourage member lifestyle changes, when possible

We want providers to have access to the most up-to-date clinical practice and preventive health care guidelines, offered by nationally recognized health care organizations and based on extensive research. These guidelines include the latest standards for treating the most common and serious illnesses, such as diabetes and hypertension. These guidelines also include recommendations for preventive screenings, immunizations and member counseling based on age and gender.

Clinical Practice and Preventive Health Care Guidelines

Clinical Practice Guidelines

Providers need the latest research on treating common conditions, such as asthma, diabetes and hypertension. The Clinical Practice Guidelines follow nationally-recognized best practices for standards of treatment and give providers a powerful tool in educating our members. The Clinical Practice Guidelines are available on the **Providers** page of our website at providers.amerigroup.com/ia**.** To access them, select **Medical** > **Clinical Practice Guidelines**. The website offers the most up-to-date clinical resources and guidelines. If you do not have Internet access, request a hard copy of the Clinical Practice Guidelines by calling Provider Services at <<1-800-454-3730>>.

The following Clinical Practice Guidelines are updated continually:

- Asthma: **Guidelines for the Diagnosis and Management of Asthma (EPR 3 Summary Report 2007)**
- Chlamydia: **2010 Sexually Transmitted Disease Treatment Guidelines**
- Chronic Heart Failure (CHF) in the Adult: **2009 Focused Update Incorporated Into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults**
- Chronic Obstructive Pulmonary Disease (COPD): **Global Initiative for Chronic Obstructive Lung Disease (GOLD)**
- Coronary Artery Disease (CAD): **Circulation–AHA/ACCF Guideline**
- Diabetes:
    - **2013 Standards of Care**
    - **Evidence Table: Standards of Medical Care in Diabetes—2013**
- High Blood Cholesterol: **Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III)**

- Human Papillomavirus (HPV): **Sexually Transmitted Diseases - Treatment guidelines 2010 (Human Papillomavirus Infections)**
- Hypertension and High Blood Pressure: **High Blood Pressure Guidelines (JNC 7)**
- Maternity and Perinatal: **Summary of Perinatal Care Guidelines 2013**
- Vascular At Risk:
    - **Vascular At Risk - Hypertension**
    - **Vascular At Risk - Hyperlididemia**

Please note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Actual member benefits and eligibility for services are determined in accordance with the requirements set forth by the state.

Clinical Practice and Preventive Health Care Guidelines

Preventive Health Care Guidelines

Good health begins with good lifestyle habits and regular exams. We support providers in helping members to take control of their own health by identifying and reducing the risk of potentially serious conditions.

The Preventive Health Care Guidelines, offered by nationally-recognized health organizations as a provider resource, are an effective tool for improving the overall health of our members by emphasizing education and behavior change. To request a hard copy of the Preventive Health Guidelines please call Provider Services at <<1-800-454-3730>>.

Please note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Actual member benefits and eligibility are determined in accordance with the requirements set forth by the state.

CHAPTER 19: CASE MANAGEMENT

Case Management Phone: **<<1-800-454-3730>>**
Case Management Fax: **<1-800-964-3627>**
Hours of Operation: **Monday to Friday, 7:30 a.m.-6 p.m.** Central time
Website: **providers.amerigroup.com/ia**

Case Management

Overview

Case management is a cooperative effort providing expert assistance to both providers and members in the coordination of complex health care. The program is designed to develop, implement, coordinate and monitor health care plans to optimize our members' health care benefits.

A case manager, through discussions with providers and members, collects data and analyzes information about actual and potential care needs for the purpose of developing a health care plan. Members referred to case management may be identified by disease or condition, or high utilization of services.

Examples of members appropriate for referral to case management include those with:

- Unmanaged chronic conditions such as asthma, diabetes and heart failure
- Complex or multiple-care cases, including multiple trauma or cancer
- Frequent hospitalizations or emergency room visits
- Hemophilia, sickle cell anemia, cystic fibrosis or cerebral palsy
- High-risk or teen pregnancies
- Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)
- Potential transplants
- Preterm births

We make the following information available to contracted providers:

- Amerigroup criteria for determining which members might benefit from case management
- Provider's responsibility for identifying members who meet that criteria
- Process for providers to follow when notifying Amerigroup about identified members

Additionally, the Case Management department provides descriptions of the programs for the following conditions or needs:

- Asthma
- Cardiovascular disease, including hypertension, coronary artery disease (CAD) and chronic heart failure (CHF)
- Children with special health care needs
- Chronic kidney disease (CKD) and end-stage renal disease (ESRD)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Oncology
- Pregnancy, high-risk obstetrics and teen pregnancy
- Special programs, including discharge transitions

Please note: Our Case Management department is sensitive to the cultural and linguistic diversity of our members and its impact on their interaction within the health care system. We encourage providers to become familiar with our cultural and linguistic training materials, available on the **Providers** page of our website at **providers.amerigroup.com**/ia**.** Go to **Medical** > **Forms** and scroll to **Cultural and Linguistic Resources**.

Case Management
Provider Responsibilities

PCPs have the responsibility of participating in the case management process by sharing information and facilitating the process as follows:

- Referring members who could benefit from case management.
- Sharing information as soon as the PCP identifies complex health care needs.
- Collaborating with Case Management staff on an ongoing basis.
- Referring members to specialists, as required.
- Providing medical information.
- Monitoring and updating the care plan to promote health care goals.
- Coordinating county or state-linked services such as public health, behavioral health, schools and waiver programs.

Case Management
Referral Process

Providers, nurses, social workers and members or their representatives may refer members to Case Management as follows:

Phone: <<1-800-454-3730>>
Fax (using the **Care Management Referral** form): <1-800-964-3627>

A case manager responds to a faxed request within three business days.

Locate the **Care Management Referral** form on the **Providers** page of our website at **providers.amerigroup.com**/ia**.**

Case Management
Role of the Case Manager

The case manager's role is to assess the member's health care status, develop a health care plan, and:

- Facilitate communication and coordination within the health care team.
- Facilitate communication with the member and his or her family in the decision-making process.
- Educate the member and provider(s) about care management, community resources, benefits, cost factors and all related topics so informed decisions may be made.
- Encourage appropriate use of medical facilities and services, with the goal of improving quality of care and maintaining cost-effectiveness on a case-by-case basis.

The Case Management department includes experienced and credentialed registered nurses, some of whom are certified case managers. The department also includes social workers, who add valuable skills allowing us to address our members' medical, psychological, social and financial issues. Interpreter services are available to support the case management process at no cost to the member.

Case Management
Case Management Procedure

When a member has been identified as having a condition that may require case management, the case manager contacts the referring provider and member for an initial assessment. With the involvement of the member, the member's representative and the provider, the case manager develops an individualized care plan. That plan may involve coordinating services with public and behavioral health departments, schools and other community health resources.

The case manager periodically reassesses the care plan to monitor the following:

- Progress toward goals
- Necessary revisions
- New issues to be addressed to ensure the member receives the support necessary to achieve care plan goals

After goals are met or case management can no longer impact the case, the case manager closes the case.

Case Management
Transitioning Disenrollees

The case manager's responsibility is to assist when a member requests help to transition to another health plan. This must occur without disruption of any regimen of care that qualifies as a continuity of care condition. The case manager works with the member, the member's providers and the case manager at the new health plan to ensure an orderly transition.

Case Management
Continued Access to Care

New Amerigroup members may receive services from out-of-network, Iowa Medicaid-certified providers if certain guidelines are met. First, the provider must contact us to discuss the scheduled health services in advance of the service date. Second, the case must meet a qualifying condition, as defined below, in which the member:

- Has been approved and scheduled to receive a cornea and/or kidney transplant or tissue replacement.
- Has been approved by the state of Iowa and scheduled to receive any other organ transplant or tissue replacement. Amerigroup will provide continuity of care for the preparation work for pre-surgery up until the member is transferred to fee-for-service Medicaid for the transplant or tissue replacement.
- Is in her second trimester of pregnancy and has an established relationship with an Iowa Medicaid-certified, out-of-network obstetrician and/or delivery hospital, or has a prior relationship with a nonparticipating provider with previous pregnancies.
- Has been scheduled for inpatient/outpatient surgery that was approved prior to transitioning to Amerigroup.
- Has appointment(s) within the initial month of Amerigroup membership. These appointments must have been scheduled prior to the effective date of transition with Iowa Medicaid-certified, out-of-network specialists.
- Has received ongoing chemotherapy or radiation treatment.
- Has enrolled a newborn effective on the date of birth and within the first 100 days of life. The child must be born to a mother who was enrolled in the health plan at the time of the birth.

- Is undergoing screening for long-term care placement.
- Is transitioning through behavioral health services, especially if the member received precertification from the previous health plan or through fee-for-service coverage.

Case Management
Continuity of Care Process

Our case management nurses review member and provider requests for continuity of care. These nurses facilitate continuation with the current provider until the regimen of care is complete or the member transitions to a new provider.

Only Amerigroup can make adverse determination decisions regarding continuity of care. Adverse determination decisions are sent in writing to the member and provider within two business days of the decision. Members and providers may appeal the decision by following the procedures in **Chapter 12: Grievances and Appeals** in this manual. Reasons for continuity of care denial include, but are not limited to:

- Course of treatment being complete
- Member being ineligible for coverage
- Condition is not a qualifying condition
- Request is for change of PCP and not for continued access to care
- Requested services are not covered benefits
- Services rendered are covered under a global fee
- Treating provider currently is contracted with Amerigroup

Case Management
Health Home Services

Overview

Effective January 2012, with CMS approval, Iowa initiated the Health Home program for Medicaid members with chronic medical and behavioral conditions. A state plan amendment on July 1, 2014, extended a statewide health home program for adults and children with mental health conditions, called Integrated Health Homes.

A Health Home supports a member's health care and service needs — physical and mental health and social supports. A Health Home appoints a care coordinator, a health care team and service providers to serve as the member's health home in collaboration with Amerigroup. Health Homes are a health service model whereby a member's health service providers and caregivers communicate with one another to address health needs in a comprehensive manner. This is accomplished with a dedicated care manager who oversees and promotes access among health providers and social service organizations to promote the member's health. Health records are shared among providers (either electronically or on paper) so that services are not duplicated or neglected. The health home services are provided through a network of organizations including providers, health plans and community-based organizations. When all of the services are considered collectively, they become a Collaborative Health Home.

A Health Home facilitates access to a range of health and community services, simplifying the process for the member. Core health home services include:

- Comprehensive care management

- Care coordination
- Transitions in care
- Support to individual and family members
- The facilitation of referrals to community services and supports
- Health promotion and self-care

The care coordinator serves as a main point of contact in coordinating between providers and supporting the member. A care coordinator:

- Coordinates care provided by doctors, therapists, counselors, individuals and community supports.
- Talks with providers to assist in setting health goals.
- Learns about member's medications to facilitate adherence and reconcile prescriptions among multiple providers.
- Identifies supports in the community, such as housing and transportation, to address social and community-based barriers to health.

Eligibility Criteria

Chronic Condition Health Home eligibility criteria require members to have one or more of the following:

- Two or more chronic conditions (e.g., mental health condition, substance use disorder, asthma, diabetes, heart disease, a BMI over 25 or other chronic conditions)
- One qualifying chronic condition (e.g., HIV/AIDS) and the risk of developing another
- One serious mental illness

Note: The PCP determines eligibility.

An Integrated Health Home (IHH) is a team of professionals working together to provide person-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). Eligibility for IHH services includes either:

- An adult with an SMI: Psychotic disorders, schizophrenia, schizoaffective disorder, major depression, bipolar disorder, delusional disorder, obsessive compulsive disorder or another mental health diagnosis with significant functional impairment.
- A child or youth with an SED: A diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current Diagnostic and Statistical Manual of mental disorders (DSM) that results in a functional impairment.

Eligibility criteria for either a Chronic Condition Health Home or IHH include:

- Members who get full Medicaid benefits
- Members who get full Medicaid benefits and who also have Medicare

Amerigroup will identify eligible members, or an IHH partner may refer a member to Amerigroup for eligibility determination.

Members in the following programs are not eligible for the Health Home program:

- Iowa Health and Wellness Plan
- Qualified Medicare Beneficiary
- Special Low-Income Medicare Beneficiary
- Program of All-Inclusive Care for the Elderly
- Iowa Family Planning Network

- Health Maintenance Organization members
- Presumptive Eligible*

**Temporary Medicaid coverage for women who are pregnant, or who need treatment for breast and cervical cancer, and children under the age of 19 who need temporary medical coverage.*

Targeted care management services are provided through the IHH.

CHAPTER 20: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Provider Services: **<<1-800-454-3730>>**
Provider Services Fax: **<<1-800-964-3627>>**
Hours of Operation: **Monday to Friday, 7:30 a.m.-6 p.m. Central time**

Quality Assessment and Performance Improvement

Overview

Amerigroup's goal is continuous, measurable improvement in our delivery of quality health care. Following federal and state guidelines, we have a Quality Assessment and Performance Improvement (QAPI) program in place to advance our levels of readiness, service and care. The QAPI program, aligned with the State of Iowa's quality standards, includes focused studies measuring quality of care in the following clinical and service areas:

- Childhood immunization status
- Comprehensive diabetes care (HbA1C Testing and LDL-C Screening)
- Chronic obstructive pulmonary disease (COPD) and chronic heart failure (CHF) care
- healthy birth outcomes
- Lead testing of 1- and 2-year-olds
- Smoking cessation
- Use of appropriate medication for asthmatics

All providers are expected to participate in these studies as part of our mutual goal of providing responsive, cost-effective health care that improves our members' lives. The studies include:

- Participation in multi-disciplinary teams for problem solving
- Population studies
- Random sample-based studies
- Satisfaction surveys

We share information from these studies with providers and encourage constructive feedback. Based on the results of the previous year's QAPI program, Amerigroup reviews and assesses the program's effectiveness and develops a new work plan for the next year's activities.

We also participate in national evaluations designed to gauge our performance and that of providers. An important measure of performance comes from the National Committee for Quality Assurance (NCQA), which annually reports the Healthcare Effectiveness Data and Information Set (HEDIS®)* scores to health care plans throughout the country. This professional evaluation serves as a yearly report card and is a tool used by more than 90 percent of America's health care plans to rate performance across a wide spectrum of care and service areas, including:

- Member satisfaction with care access
- Member satisfaction with claims processing
- Customer service

Amerigroup uses the HEDIS data to identify areas for improvement and shares the results with providers. We submit the results of the HEDIS assessment and our own quality studies annually to the Iowa Department of Human Services (DHS), which makes the results public. As a result, HEDIS summaries may be used by potential members to make comparisons before choosing a health care plan.

**HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQ).*

We also are committed to tracking preventable adverse medical events, also known as “never events”, with the ultimate goal of eliminating these events.

Please note: If we determine that the quality of care or services provided by a health care professional is not satisfactory, Amerigroup may terminate the Provider Agreement and related addendums. We make this determination by reviewing member satisfaction surveys, case management data, member complaints or grievances, other complaints or lawsuits alleging professional negligence, or quality of care indicators.

Quality Assessment and Performance Improvement

Quality Assessment and Performance Improvement Program

The QAPI program focuses on developing and implementing standards for clinical care and service, measuring conformity to those standards and taking action to improve performance. The scope of the QAPI program includes, but is not limited to, the monitoring and evaluation of:

- Care and service provided in all health delivery settings
- Internal organizational performance
- Provider/member satisfaction
- Provider promotion of preventive health programs and exams
- Provider management of member health status
- Provider site facilities and medical records

Amerigroup develops an annual plan of quality improvement activities based on the results of the previous year’s QAPI program evaluation. Then we review, evaluate and revise the QAPI program’s effectiveness. The evaluation is a written description of the ability of Amerigroup to implement the QAPI program, meet program objectives, and develop and implement plans to improve the quality of care and service to our members.

Providers support the activities of the QAPI program by:

- Completing corrective action plans, when applicable
- Participating in the facility and medical record audit process
- Providing access to medical records for quality improvement projects and studies
- Responding in a timely manner to requests for written information and documentation, if a quality of care or grievance issue has been filed
- Using preventive health and clinical practice guidelines in member care

Quality Assessment and Performance Improvement

Healthcare Effectiveness Data and Information Set

HEDIS is a national evaluation and core set of performance measurements gauging the effectiveness of Amerigroup and providers in delivering quality care. We are ready to help when providers and their office staff need training to participate in required HEDIS evaluations. Providers can request consultations and training in the following areas:

- Information about the year’s selected HEDIS studies
- How data for those measures will be collected
- Codes associated with each measure
- Tips for smooth coordination of medical record data collection

Our Quality Improvement staff will contact the provider's office when we need to review or copy any medical records required for quality improvement studies. Office staff must provide access to medical records for review and copying.

Quality Assessment and Performance Improvement
Quality Management

Twice a year, and in accordance with NCQA standards, Amerigroup analyzes relevant utilization data against established thresholds for each health plan to detect current utilization levels. If our findings fall outside specified target ranges and indicate potential under-utilization or over-utilization, further analysis will occur based on the recommendation of Amerigroup's Utilization Management committee. The follow-up analysis may include gathering the following data from specific provider and practice sites:

- Case management services needed by members
- Claims payments for covered services
- Coordination with other providers and agencies
- Focus studies
- Investigation and resolution of member and provider complaints and appeals within established time frames
- Retrospective reviews of services provided without authorization

Quality Assessment and Performance Improvement
Best Practice Methods

Best practice methods are Amerigroup's most up-to-date compilation of effective strategies for quality health care delivery. We share best practice methods during site visits to provider offices. Member Services and Network Management departments offer policies, procedures and educational toolkits to help guide improvements. Toolkits may include examples of best practices from other offices, including:

- Resources for improving compliance with preventive health services
- Clinical practice guidelines
- Care for members with special or chronic care needs

Quality Assessment and Performance Improvement
Member Satisfaction Surveys

Member satisfaction with Amerigroup's health care services is measured every year by the NCQA. The NCQA conducts a survey called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The survey is designed to measure member satisfaction with our services, including:

- Access to care
- Amerigroup customer service
- Provider communications
- Provider office staff performance

We distribute the results of the CAHPS survey to both members and providers. Providers should review the results, share the results with office staff and incorporate appropriate changes in their offices.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Quality Assessment and Performance Improvement
Provider Satisfaction Surveys

Amerigroup may conduct provider surveys to monitor and measure provider satisfaction with our services and identify areas for improvement. Provider participation in these surveys is highly encouraged and your feedback is very important. We inform providers of the results and plans for improvement through provider bulletins, newsletters, meetings or training sessions.

Quality Assessment and Performance Improvement
Medical Record and Facility Site Reviews

We conduct medical record and facility site reviews to determine provider:

- Compliance with standards for providing health care.
- Compliance with standards for storing medical records.
- Compliance with processes that maintain safety standards and practices.
- Involvement in the continuity and coordination of member care.

Please note: The Iowa DHS and Amerigroup have the right to enter the premises of providers to inspect, monitor, audit or otherwise evaluate the work performed. We perform all inspections and evaluations in such a manner as to not unduly delay work, in accordance with the Provider Agreement.

Quality Assessment and Performance Improvement
Medical Record Documentation Standards

Amerigroup requires providers to maintain medical records in a manner that is current, organized, and permits effective and confidential member care and quality review. Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act, which requires the following:

- Providers of health care are prohibited from disclosing any individually identifiable information regarding a patient's medical history, mental condition, physical condition or treatment without the patient's or legal representative's consent or specific legal authority.
- Records required through a legal instrument may be released without patient or patient representative consent.
- Providers must be familiar and in compliance with the security requirements of HIPAA.

Quality Assessment and Performance Improvement
Medical Record Security

Medical records must be secure and inaccessible to unauthorized access to prevent loss, tampering, disclosure of information, alteration or destruction of the records. Information must be accessible only to authorized personnel within the provider’s office, Amerigroup, the Iowa DHS or to persons authorized through a legal instrument. Records must be made available to Amerigroup for purposes of quality review, HEDIS and other studies.

Quality Assessment and Performance Improvement
Storage and Maintenance

Active medical records should be stored in a central medical record area and must be inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed and organized, permitting effective patient care and quality review while maintaining confidentiality. Inactive records are to remain accessible for a period of time that meets state and federal guidelines.

Quality Assessment and Performance Improvement
Availability of Medical Records

The medical record system must allow for prompt retrieval of each record when the member comes in for a visit. Providers must maintain members' medical records in a detailed and comprehensive manner that accomplishes the following:

- Conforms to good professional medical practice
- Facilitates an accurate system for follow-up treatment
- Permits effective, professional medical review and medical audit processes

Medical records must be legible, signed and dated, and maintained for at least seven years as required by state and federal regulations.

Providers must supply a copy of a member's medical record upon reasonable request by the member at no charge. The provider also must facilitate the transfer of the member's medical record to another provider at the member's request. Access to medical records and confidentiality must be provided in accordance with the standards mandated in HIPAA and all other state and federal requirements.

Providers must permit Amerigroup and Iowa's Health Link representatives to review members' medical records for the purposes of monitoring the provider's compliance with the medical record standards, capturing information for clinical studies, monitoring quality or any other reason. Amerigroup encourages providers to use technology, such as health information exchanges, to transmit and store medical record data.

Quality Assessment and Performance Improvement
Medical Record Requirements

At a minimum, every medical record must include:

- The patient's name or identification (ID) number on each page in the record
- Personal biographical data, including home address, employer, emergency contact name and phone number, home and work phone numbers and marital status
- Entries dated with month, day and year
- Entries documented with the author's identification and title. For example, handwritten signature, unique electronic identifier or initials
- Identification of all providers participating in the member's care
- Information on the services furnished by these providers
- List of problems, including significant illnesses, medical conditions, and psychological conditions
- Presenting complaints, diagnoses and treatment plans, including the services to be delivered
- Physical findings relevant to the visit, including vital signs, normal and abnormal findings, and appropriate subjective and objective information

- Information on allergies and adverse reactions, or a notation that the patient has no known allergies or history of adverse reactions
- Information on advance directives
- Past medical history, including serious accidents, operations and illnesses. In addition:
    - For patients 14 years old and older, the record must include information about substance abuse
    - For children and adolescents, the record must include past medical history as relates to prenatal care, birth, operations, and childhood illnesses
- Notations concerning the use of cigarettes, alcohol and substance abuse for patients 14 years and older, including anticipatory guidance and health education
- Physical examinations, treatment necessary and possible risk factors relevant to the particular treatment
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Information about the individuals to be instructed in assisting the patient
- Medical records must be legible, dated and signed by the provider, physician assistant, nurse practitioner, or nurse midwife providing patient care
- Up-to-date immunization record for children, or an appropriate history for adults
- Documentation of attempts to provide immunizations. If the member refuses immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the member or guardian shall be documented in the member's medical record
- Evidence of preventive screening and services, in accordance with Amerigroup 's preventive health practice guidelines
- Documentation of referrals, consultations, diagnostic test results, and inpatient records. Evidence of the provider's review may include the provider's initials or signature and notation in the patient's medical record. The provider may indicate review and patient contact, follow-up treatment, instructions, return office visits, referrals, and other patient information
- Notations of patient appointment cancellations or "no-shows" and the attempts to contact the patient to reschedule
- No indication or implication that the patient was placed at inappropriate risk by a diagnostic test or therapeutic procedure
- Documentation on whether an interpreter was used in any initial or follow-up visit

Quality Assessment and Performance Improvement

Advance Directives

Recognizing a person's right to dignity and privacy, our members have the right to execute an advance directive, also known as a living will, to identify their wishes concerning health care services should they become incapacitated. Providers are expected to adhere to the following guidelines:

- Discuss the sensitive issues raised by advance directives with patients and their families.
- Advise members of their right to change or revoke their advance directive at any time.
- Advise members of their right to contact Member Services to request additional information about advance directives.
- Document in the member's medical record the discussion about advance directives.
- Document in the member's medical record whether or not an advance directive has been completed.
- Place a copy of a completed advance directive in the member's medical record.

Quality Assessment and Performance Improvement
Medical Record Review Process

A member of our Quality Improvement department will call the provider's office to schedule a medical record review on a date and time occurring within 30 days. On the day of the review, the Quality Improvement associate will:

1. Request the number and type of medical records required.
2. Review the appropriate type and number of medical records per provider.
3. Complete the medical record review.
4. Meet with the provider or office manager to review and discuss the results of the medical record review.
5. Provide a copy of the medical record review results to the office manager or provider, or send a final copy within 10 days of the review.
6. Schedule follow-up reviews for any corrective actions identified.

Providers must attain a score of 80 percent or greater to pass the medical record review. Amerigroup conducts a medical record review annually, according to our medical records standards, at select primary care sites and high-volume provider offices.

Quality Assessment and Performance Improvement
Facility Site Review Process

An initial site inspection is required for all provider offices participating in Amerigroup, regardless of other accreditation or certification. In addition:

- A site review is required as part of the initial credentialing process for new providers if that site has not been reviewed and accepted as part of Amerigroup's credentialing process.
- Obstetrics/Gynecology (OB/GYN) specialist sites participating in our plan and not serving as PCPs also must undergo an initial site inspection.

A member of our Quality Improvement department will call the provider's office to schedule an appointment date and time before the facility site review due date. The department will fax or mail a confirmation letter with an explanation of the audit process and required documentation.

During the facility site review, the Quality Improvement associate will:

1. Lead a prereview conference with the provider or office manager to review and discuss the process of facility review and answer any questions.
2. Conduct a review of the facility.
3. Develop a corrective action plan, if applicable.

After the facility site review is completed, our associate will meet with the provider or office manager to:

1. Review and discuss the results of the facility site review and explain any required corrective actions.
2. Provide a copy of the facility site review results and the corrective action plan to the provider or office manager, or mail a final copy within 10 days of the review.
3. Educate the provider and office staff about our standards and policies.
4. Schedule a follow-up review for any corrective actions identified.

Quality Assessment and Performance Improvement
Facility Site Review: Corrective Actions

If the facility site review results in a nonpassing score, Amerigroup will notify providers immediately of the nonpassing score, all cited deficiencies and corrective action requirements. The provider office will develop and submit corrective action plans and we will conduct follow-up visits every six months until the site complies with our standards.

The provider and office staff will:

1. Make an appointment time available for the review.
2. Be available to answer questions and participate in the exit interview.
3. Schedule follow-up reviews, if applicable.
4. Complete a corrective action plan.
5. Sign an attestation that corrective actions are complete.
6. Submit the completed corrective action plan, supporting documents and signed attestation to our quality improvement analyst.

Quality Assessment and Performance Improvement
Preventable Adverse Events

The breadth and complexity of today's health care system means there are inherent risks, many of which can be neither predicted nor prevented. However, preventable adverse events should be tracked and reduced, with the ultimate goal of eliminating these events.

Providers and health care systems, as advocates for our members, are responsible for the continuous monitoring, implementation and enforcement of applicable health care standards. Focusing on patient safety, we work collaboratively with providers and hospitals to identify preventable adverse events and implement appropriate strategies and technologies to avoid these events. Our goal is to enhance the quality of care received not only by our members, but all patients receiving care in these facilities.

Prevention of adverse events may require the disclosure of protected health information (PHI). HIPAA specifies that PHI may be disclosed for the purpose of health care operations in relation to quality assessment and improvement activities. Moreover, the information you share with us is legally protected through the peer review process and will be maintained in a strictly confidential manner. If you receive a request for medical records, please provide the records within 10 days from the date of request.

We will continue to monitor activities related to the list of adverse events from federal, state and private payers, including "never events":

> **Never events:** As defined by the National Quality Forum (NQF), never events are adverse events that are serious, but largely preventable, and of concern to both the public and health care providers.

Preventable adverse events should not occur. When they do, we firmly support the concept that a health plan and its members should not pay for resultant services.

Please note: Medicaid is prohibited from paying for certain Health Care Acquired Conditions (HCAC) and this ruling applies to all hospitals.

CHAPTER 21: ENROLLMENT AND MARKETING RULES

Provider Services: **<<1-800-454-3730>>**
Provider Services Fax: **<<1-800-964-3627>>**
Hours of Operation: **Monday to Friday, 7:30 a.m.-6 p.m. Central time**

Enrollment and Marketing Rules
Overview

The delivery of quality health care poses numerous challenges, not the least of which is the commitment shared by Amerigroup and providers to act in the best interest of our members. We want our members to make the best health care decisions possible. And when members ask for our assistance, we want to provide that assistance so they make those decisions without undue influence.

We recognize that providers occupy a unique, trusted and respected part of people's lives. Given the complexity of modern-day healthcare and the inherent difficulties communicating with some of the populations we serve, there are potentially serious pitfalls when providers try to assist in the decision-making process. Sometimes, even though the intent is to help make our members' lives better, we may overstep.

For that reason, we are committed to following strict enrollment and marketing guidelines created by the Iowa Department of Human Services (DHS), and to honoring the rules for all state health care programs.

Enrollment and Marketing Rules
Marketing Policies

Amerigroup providers are prohibited from making marketing presentations and advising or recommending to an eligible individual that he or she select membership in a particular plan. The DHS marketing practice policies prohibit network providers from making any of the following false or misleading claims:

- The PCP's office staff are employees or representatives of the state, county or federal government
- Amerigroup is recommended or endorsed by any state or county agency, or any other organization
- The state or county recommends that a prospective member enroll with a specific health care plan
- A prospective member or medical recipient loses Medicaid or other welfare benefits if the prospective member does not enroll with a specific health care plan

These policies also prohibit network providers from taking the following actions:

- Making marketing presentations, advising or recommending to an eligible individual that he or she select membership in a specific health care plan.
- Offering or giving away any form of compensation, reward or loan to a prospective member to induce or procure member enrollment in a specific health care plan.
- Engaging in direct marketing to members designed to increase enrollment in a particular health care plan. The prohibition should not constrain providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.
- Using any list of members originally obtained for enrollment purposes from confidential state or county data sources, or from the data sources of other contractors.
- Employing marketing practices that discriminate against potential members other than persons specifically excluded from coverage under our contract. Providers may not discriminate based on marital

status, age, religion, sex, national origin, language, sexual orientation, ancestry, or pre-existing psychiatric problem or medical condition, such as pregnancy, disability or AIDS.

- Reproducing or signing an enrollment application for the member.
- Displaying materials only from the provider's contracted managed health care organizations and excluding others.

Providers are permitted to:

- Assist members in applying for benefits by calling Amerigroup for enrollment information:

  Phone: <1-800-600-4441>
  TTY: 711
  Health Maintenance Organization (HMO) enrollment specialist: <1-800-291-2002>
- Distribute copies of Amerigroup applications to potential members.
- File a complaint with Amerigroup if a provider or member objects to any form of marketing, either by other providers or by Amerigroup representatives. Refer to **Chapter 12: Grievances and Appeals** in this manual for more information on the grievance process.

Enrollment and Marketing Rules

Enrollment Process

DHS determines the eligibility and enrollment for individuals seeking to enroll in IA Health Link, after which the process is as follows:

- DHS presents IA Health Link to eligible individuals and families.
- DHS informs Amerigroup of new member enrollment.
- Providers are given notice of new members assigned to their care through monthly eligibility reports. Providers access these reports by logging into Availity, the secure provider portal on the **Providers** page of our website at **providers.amerigroup.com**/ia. Click on **Login** or **Register** and register or log on to access the site.
- Amerigroup sends each new member a New Member Kit within five business days of receiving the DHS monthly membership file. This kit includes the Member Handbook, an information card with important phone numbers, and instructions for changing a PCP.
- Members select a PCP. After 14 days, if the member has not selected a PCP, Amerigroup assigns a PCP to the member.

CHAPTER 22: FRAUD, ABUSE AND WASTE

Provider Services: **<<1-800-454-3730>>**
Provider Services Fax: **<<1-800-964-3627>>**
Hours of Operation: **Monday to Friday, 7:30 a.m.-6 p.m. Central time**

Fraud, Abuse and Waste
Overview

We are committed to protecting the integrity of our health care program and the efficiency of our operations by preventing, detecting and investigating fraud, abuse and waste.

Fraud, Abuse and Waste
Understanding Fraud, Abuse and Waste

Combating fraud, abuse and waste begins with knowledge and awareness.

> **Fraud:** Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it -- or any other person. The attempt itself is fraud, regardless of whether or not it is successful.
>
> **Abuse:** Any practice inconsistent with sound fiscal, business or medical practices that results in an unnecessary cost to the Medicaid program, including administrative costs from acts that adversely affect providers or members.
>
> **Waste:** Generally defined as activities involving careless, poor or inefficient billing or treatment methods causing unnecessary expenses and/or mismanagement of resources.

Fraud, Abuse and Waste
Examples of Provider Fraud, Abuse and Waste

The following are examples of provider fraud, abuse and waste:

- Altering medical records
- Billing for services not provided
- Billing for medically unnecessary tests
- Billing professional services performed by untrained personnel
- Misrepresentation of diagnosis or services
- Over-utilization
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling
- Under-utilization
- Up coding

Fraud, Abuse and Waste
Examples of Member Fraud, Abuse and Waste

The following are examples of member fraud, abuse and waste:

- Disruptive or threatening behavior
- Frequent emergency room visits for nonemergent conditions

- Forging, altering or selling prescriptions
- Letting someone else use a member's IA Health Link identification (ID) card
- Not telling the truth about the amount of money or resources the member has for the purpose of obtaining benefits
- Not telling the truth about a medical condition to obtain medical treatment
- Obtaining controlled substances from multiple providers
- Relocating to an out-of-service area
- Using multiple providers to obtain similar treatments and/or medications
- Using a provider not approved by the PCP
- Using someone else's IA Health Link ID
- Violating the Pain Management Contract

Pain Management Contract: A written agreement between a provider and member that the member will not misrepresent his or her need for medication. If the contract is violated, the provider has the right to drop the member from his or her practice.

Fraud, Abuse and Waste

Reporting Provider or Recipient Fraud, Abuse or Waste

If you suspect either a provider (doctor, dentist, counselor, etc.) or member (a person who receives benefits) has committed fraud, abuse or waste, you have the right and responsibility to report the incident.

Provider Reporting

Providers may report allegations of fraud, abuse or waste by contacting Amerigroup:

Phone: <<1-800-454-3730>>
Fax: <<1-800-964-3627>>
Mail:

Amerigroup Iowa, Inc.
ATTN: MSIU
P.O. Box 62509
Virginia Beach, VA 23466

Member Reporting

Members should let us know if they suspect a doctor, dentist, pharmacist other health care providers, or another person receiving benefits is doing something wrong. Members should contact us as follows:

Member Services phone: <<1-800-600-4441>>
TTY: <<711>>
Mail:

Amerigroup Iowa, Inc.
Attn: MSIU
P.O. Box 62509
Virginia Beach, VA 23466

Both providers and members may report waste, fraud and abuse by completing our Waste, Fraud and Abuse Report form online at our website: providers.amerigroup.com/ia**.** To locate this form, select **Waste, Fraud, & Abuse** at the bottom of our **Providers** page.

When reporting about a provider, include the following:

- Name, address, and phone number of the provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if available
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

When reporting about a member who receives benefits, include the following:

- The person's name
- The person's date of birth, Social Security number, or case number, if available
- The city where the person lives
- Specific details about the fraud, abuse or waste

Fraud, Abuse and Waste
Anonymous Reporting of Suspected Fraud, Abuse and Waste

Any incident of fraud, abuse or waste may be reported to us anonymously. However, in certain instances, we may not be able to pursue an investigation without additional information. In such cases, we will need the following:

- The name of the person reporting and their relationship to the person suspected
- A call-back phone number for the person reporting the incident

Please note: The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators to maintain that person's anonymity.

Fraud, Abuse and Waste
Investigation Process

We do not tolerate acts that adversely affect providers or members. We investigate all reports of fraud, abuse and waste. Allegations and the investigative findings are reported to the Department of Human Services (DHS), regulatory agencies and law enforcement agencies. In addition to reporting, we take corrective action, such as:

- **Written warning and/or education**: We send certified letters to the provider or member documenting the issues and need for improvement. Letters may include education or request for recoveries, or may advise of further action.
- **Medical record audit**: We may review medical records to substantiate allegations or validate claims submissions.
- **Special claims review**: A special claims review places payment or system edits on file to prevent automatic claim payment. This type of review requires a medical reviewer evaluation.
- **Recoveries**: We recover overpayments directly from the provider within 30 days. Failure of the provider to return the overpayment may be reflected in reduced payment of future claims or further legal action.

Fraud, Abuse and Waste
Acting on Investigative Findings

We refer all criminal activity conducted by a member or provider to the appropriate regulatory and law enforcement agencies. If a provider has committed fraud, abuse or waste, the provider:

- Will be referred to the Quality Management department.
- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination.

Failure to comply with program policy, procedures or any violation of the contract will result in termination from our plan.

If a member has committed fraud, exhibited abusive or threatening behavior, or has failed to correct issues, he or she may be involuntarily disenrolled from our health care plan, with state approval. Refer to **Chapter 11: Member Transfers and Disenrollment** for more information**.**

Fraud, Abuse and Waste
False Claims Act

We are committed to complying with all applicable federal and state laws, including the federal False Claims Act (FCA). The FCA is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits, or causes another person or entity to submit, false claims for payment of government funds is liable for three times the damages, or loss, to the government, plus civil penalties of $5,500 to $11,000 per false claim.

The FCA also contains Qui Tam or “whistleblower” provisions. A “whistleblower” is an individual who reports in good faith an act of fraud or waste to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

Fraud, Abuse and Waste
Employee Education about the False Claims Act

As a requirement of the Deficit Reduction Act of 2005, contracted providers who receive Medicaid payments of at least five million dollars (cumulative from all sources), must comply with the following:

- Establish written policies for all employees, managers, officers, contractors, subcontractors and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
- Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing Fraud, Waste, and Abuse.
- Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, abuse and waste.

CHAPTER 23: MEMBER RIGHTS AND RESPONSIBILITIES

Member Services: **<<1-800-600-4441>>**
TTY: **<<711>>**
Hours of Operation: **Monday to Friday, 7:30 a.m.-6 p.m. Central time**

Member Rights and Responsibilities

Overview

Members should be clearly informed about their rights and responsibilities so they can make the best health care decisions. Members also have the right to ask questions about the way we conduct business, as well as the responsibility to learn about their health care plan coverage.

The following member rights and responsibilities are defined by the state of Iowa and appear in the Amerigroup Iowa, Inc. Member Handbook.

Member Rights and Responsibilities

Member Rights

Amerigroup honors civil rights and provides covered services to all eligible members regardless of:

- Age
- Color
- Disability
- Marital status
- National origin
- Race
- Religion
- Gender
- Sexual orientation
- Taking part in the military
- Arrest or conviction record

All medically necessary covered services are offered to all members. All services are given in the same way to all members. All persons or groups who work with Amerigroup, or who refer or suggest services to members, shall do so in the same way for all members. Translation or interpretation services are offered free of charge for those members who need assistance.

Members of Amerigroup have the right to:

- Ask for an oral Interpreter and have an interpreter given to them during any IA Health Link-covered service.
- Get the information given in the Member Handbook in another language or format.
- Get health care services as given by federal and state law. All covered services must be offered and accessible. When medically needed, services must be offered 24 hours a day, 7 days a week.
- Get details about treatment options, such as the right to ask for a second opinion.
- Make decisions about their health care.
- Be treated with dignity and respect.
- Be free from any form of restraint or seclusion used as means of force, control, convenience or retaliation.

Member Rights and Responsibilities

Member Responsibilities

Members of Amerigroup have the responsibility to:

- Show their IA Health Link ID card each time they receive medical care.
- Make or change appointments.
- Get to appointments on time.
- Call their PCP if they cannot make it to their appointment or if they will not be on time.
- Use the emergency room only for true emergencies.
- Pay for any services they ask for that are not covered by IA Health Link.
- Treat their PCP and other health care providers with respect.
- Tell us, their PCP and their other health care providers what they need to know to treat them.
- Do the things that keep them from getting sick.
- Follow the treatment plans members, their PCP and their other health care providers agree on.
- Tell us and their County/Tribal Economic Support caseworker if:
  - They move
  - They change their phone number
  - The number of people in their household changes
  - They have other insurance
  - They become pregnant

Member Rights and Responsibilities

NCQA Requirements

The organization's member rights and responsibilities statement specifies that members have:

1. A right to receive information about the organization, its services, its practitioners, its providers and member rights and responsibilities.
2. A right to be and their right to privacy.
3. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
4. A right to voice complaints or appeals about the organization or the care it provides.
5. A right to make recommendations regarding the organization's member rights and responsibilities policy.
6. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

CHAPTER 24: CULTURAL DIVERSITY AND LINGUISTIC SERVICES

Provider Services: **<<1-800-454-3730>>**
Provider Services Fax: **<<1-800-964-3627>>**
Hours of Operation: **Monday to Friday, 7:30 a.m.-6 p.m. Central time**

Cultural Diversity and Linguistic Services

Overview

Amerigroup recognizes that providing health care services to a diverse population may present challenges. Those challenges arise when providers need to cross a cultural divide to treat members who may have different behaviors, attitudes and beliefs concerning health care, or who speak a different language. Differences in our members' ability to speak or read the same language as their health care providers may add an extra dimension of difficulty when providers try to encourage follow-through on treatment plans. Our Cultural Diversity and Linguistic Services toolkit, called Caring For Diverse Populations, was developed to give you specific tools for breaking through cultural and language barriers in an effort to better communicate with your patients.

Sometimes the solution is as simple as finding the right interpreter for an office visit. Other times, a greater awareness of cultural sensitivities opens the door to the kind of interaction that makes treatment plans most effective: Has the patient been raised in a culture that frowns upon direct eye contact or receiving medical treatment from a member of the opposite sex? Is the patient self-conscious about his or her ability to read instructions?

The Cultural Diversity and Linguistic Services toolkit provides the information you will need to answer those questions and continue building trust. The toolkit will enhance your ability to communicate with ease, talking to a wide range of people about a variety of culturally-sensitive topics. The toolkit also offers cultural and linguistic training to your office staff, enabling all aspects of an office visit to go smoothly.

We strongly encourage you to access the complete Toolkit on the **Providers** page of our website at **providers.amerigroup.com**/ia. Select **Medical** > **Forms**, and scroll down to **Cultural and Linguistic Resources**.

The toolkit contents are organized into the following sections:

Improving Communications with a Diverse Patient Base

- Encounter tips for providers and their clinical staff
- A memory aid to assist with patient interviews
- Help in identifying literacy problems

Tools and Training for Your Office in Caring for a Diverse Patient Base

- Interview guide for hiring clinical staff who have an awareness of cultural competency issues
- Availability of medical consumerism training for health educators to share with patients.

Resources to Communicate Across Language Barriers

- Tips for locating and working with interpreters
- Common signs and sentences in many languages
- Language identification flashcards
- Language skill self-assessment tools

Primer on How Cultural Background Impacts Health Care Delivery

- Tips for speaking with people across cultures about a variety of culturally-sensitive topics
- Information about health care beliefs of different cultural backgrounds

Regulations and Standards for Cultural and Linguistic Services

Identifies important legislation impacting cultural and linguistic services, including a summary of the Culturally and Linguistically Appropriate Services (CLAS) standards which serve as a guide on how to meet these requirements.

Resources for Cultural and Linguistic Services

- A bibliography of print and Internet resources for conducting an assessment of the cultural and linguistic needs of your own practice's patient population
- Staff and provider cultural and linguistic competency training resources
- Links to additional tools in multiple languages and/or written for limited-English proficiency

The toolkit contains materials developed by and used with the permission of the Industry Collaboration Effort (ICE) Cultural and Linguistic Workgroup, a volunteer, multi-disciplinary team of providers, health plans, associations, state and federal agencies and accrediting bodies working collaboratively to improve health care regulatory compliance through public education. More information on the ICE workgroup may be obtained on their website at **www.iceforhealth.org.**

Cultural Diversity and Linguistic Services

Interpreter Services

For those instances when you cannot communicate with a member due to language barriers, interpreter services are available at no cost to you or the member. Amerigroup provides over-the-phone and face-to-face interpreters. Providers must notify members of the availability of interpreter services and strongly discourage the use of friends and family, particularly minors, to act as interpreters. Face-to-face interpreters for members needing language assistance, including American Sign Language, are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required.

Request telephone interpreter services by calling:

Providers: <<1-800-454-3730>>
Members: <<1-800-600-4441>>
Amerigroup On Call (after hours): <<1-800-600-4441>>

For after-hours interpreter services, call the Amerigroup On Call and take the following steps:

1. Give the member's identification (ID) number to Member Services.
2. Explain the need for an interpreter and state the language required.
3. Wait on the line while the connection is made.
4. Once connected to the interpreter, the associate or Amerigroup On Call nurse introduces the Amerigroup member, explains the reason for the call, and begins the dialogue.

Request face-to-face interpreter services by calling:

Providers: <<1-800-454-3730>>
Members: <<1-800-600-4441>>(TTY 711)

Additional information on interpreter services is available on the **Providers** page of our website at **providers.amerigroup.com**/ia. Select **Medical** > **Forms**, and scroll down to **Cultural and Linguistic Resources** and select **Interpreter Services Desktop Reference**.

Services for Members with Hearing Loss, Visual and/or Speech Impairment

During business hours, members with hearing loss or speech impairment can call the designated Amerigroup TTY numbers noted in **Chapter 3: Contact List**. After regular business hours, members can call the Amerigroup On Call TTY number <<711>>**.** The Iowa relay service is also available 24 hours a day by calling the numbers noted in **Chapter 3: Contact List**. Members can also request face-to-face sign language interpreters at no cost. Members with visual impairments can request verbal assistance or alternative formats for assistance with printed materials at no cost.

Translation of Materials

Members can request translation of materials into non-English languages, at no cost, by contacting the appropriate Member Services number in **Chapter 3: Contact List**.

Appendix A - Value Added Services

Health and Wellness Services	
Tobacco cessation counseling	Amerigroup will offer a tobacco cessation counseling benefit that provides telephonic coaching in addition to the pharmacological smoking cessation treatments available under the Iowa Medicaid Formulary consistent with CDC/PHS Guidelines for benefit design
Waived co-pays for specific services	To help promote access to preventative care and increase member attendance for various physical, preventative, wellness and behavioral health visits, Amerigroup will waive select member copayments.
Weight Watchers® class voucher	Amerigroup will offer Weight Watchers or similar vouchers to help obese adults lose weight and develop healthy lifestyle habits. We will waive initiation fees and provide four free weeks of classes. Members who meet the participation requirements will receive vouchers to attend the first four weeks of classes at no cost to them.
Personal exercise kit	To further help reduce Iowa's obesity rate, Amerigroup will offer personal exercise kits to promote healthy exercise to adults with a primary or secondary clinical diagnosis of obesity. The personal exercise kit will include various pieces of equipment to maintain muscle tone while increasing strength, flexibility, mobility and to improve health. Kit may include items such as an exercise band, weights, hydration bottle, and squeeze ball.
Healthy Families nutrition and fitness program	Amerigroup will offer the Healthy Families Program to families with potentially overweight pre-teen children. The six-month program focuses on fitness and nutrition via regularly scheduled phone calls to engage members in behavior change. Nurse Coaches send educational material via mail and refer members to online resources and local activities, when available. The Healthy Families Program connects mind and body, parents and children, to focus on healthy lifestyle choices with: • A family-centric approach • Multiple levels of support via the family and community • Availability of tangible materials for participants • Web-based resources for further resources
Boys and Girls Club® membership	To help promote the importance of an active and healthy lifestyle, Amerigroup will offer free BGC memberships for children at participating clubs.

Oral hygiene kit	Amerigroup will provide oral hygiene kits with educational materials and supplies to help members maintain good dental and oral health. • For members ages 10 and under, the kit includes kid-focused educational materials, toothpaste for children, and a youth toothbrush • For members older than 10, the kit includes items such as toothpaste, toothbrush, and dental floss.
Home delivered meals	To help enable members to focus on recovery, alleviate stress and potentially reduce hospital readmission rates, Amerigroup will provide free home-delivered meals to recently discharged members and their families.
Post-discharge stabilization kit	To further support recently discharged members, Amerigroup will also provide a post-discharge stabilization kit. Kits will include items to facilitate member education, maintain appointment attendance, and improve medication and treatment plan adherence. Kits may also include telemonitoring and/or medication adherence solutions.

Training and Support Services	
Amerigroup Community Resource Link	To help ensure our members are aware of all local Iowa community-based services, we will provide members access to our Amerigroup Community Resource link. This searchable online resource for community-based programs, benefits, and services is structured in an easy-to-use format and searchable with GPS technology. The Amerigroup Community Resource link will be a reliable source and valuable tool regarding the wide range of programs and services available throughout Iowa.
High School Equivalency Test (HiSet®) assistance	To help encourage members to obtain a high school-level education, Amerigroup will cover the costs of a high school equivalency test (HiSET) preparation course as all required tests.
Personal backpack	To help our members maintain a sense of stability and ownership, Amerigroup will provide a personal backpack for eligible children. We will regularly update the selection of available backpacks so that choices remain current. Backpacks may include items such as health education tip sheets, school supplies, journals, and drawing supplies.
Comfort item	To help promote a sense of security, Amerigroup will provide a comfort item for eligible children. The Comfort Item Value- Added Service includes a stuffed animal or journal for our adolescent and young adult members.

Financial management support	Amerigroup will offer financial education and coaching to members and their families interested in developing skills to positively influence decision making to obtain greater control over personal finances. Members and their families are eligible for a financial health assessment, access to a financial helpdesk to develop strategies to build financial capacity, and webinars or virtual self-paced step-by-step programs.
Self-Advocacy memberships	To help members develop skills for increased independence and support community living and/or community integration, Amerigroup will provide eligible members an annual stipend to attend a conference or event sponsored by Iowans with Disabilities in Action, NAMI-Iowa, or Area Agencies on Aging.
Travel training	To help promote independence, community engagement, and access to community resources, Amerigroup will provide travel training assistance benefits to eligible members.
Supported employment	To help members search for meaningful employment, Amerigroup will offer supported employment services for eligible members with brain injury and intellectual disability that exceed unit caps in the BI and ID 1915(c) waiver programs.

Independent Living Skills Services	
Additional personal care attendant supports	To help keep members in their homes and reduce the risks of institutionalization, Amerigroup will provide additional Personal Care Attendant (PCA) supports to eligible members.
Additional respite care services	To help ensure member's caregivers are provided 'breaks', Amerigroup will provide additional hours of respite care for caregivers of eligible members
Transportation assistance	To help ensure members can access therapeutic appointments, Amerigroup will offer transportation to and from scheduled appointments for eligible members and their families.
Assistive devices	To maximize independence, promote home safety, and support community living and/or community integration, Amerigroup will provide additional assistive device benefits to eligible members.

Additional minutes through Safelink®	To help ensure our members always have a way to contact us, eligible members will receive a free cellphone and plans of up to 250 minutes per month at no cost. Our members receive an additional 100 bonus lifetime minutes and free health information text messages.
Durable medical equipment and supplies	To maximize independence, promote safety and well-being, and support community living and/or community integration, Amerigroup will provide access to Durable Medical Equipment (DME) and supplies when Medicaid covered benefits do not adequately address identified service needs.
Community reintegration benefit	To help assist members reintegrate into their communities, Amerigroup will provide a community reintegration benefit for eligible members.


ia
health
link


Amerigroup
An Anthem Company